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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION, INC. • JANUARY 1974

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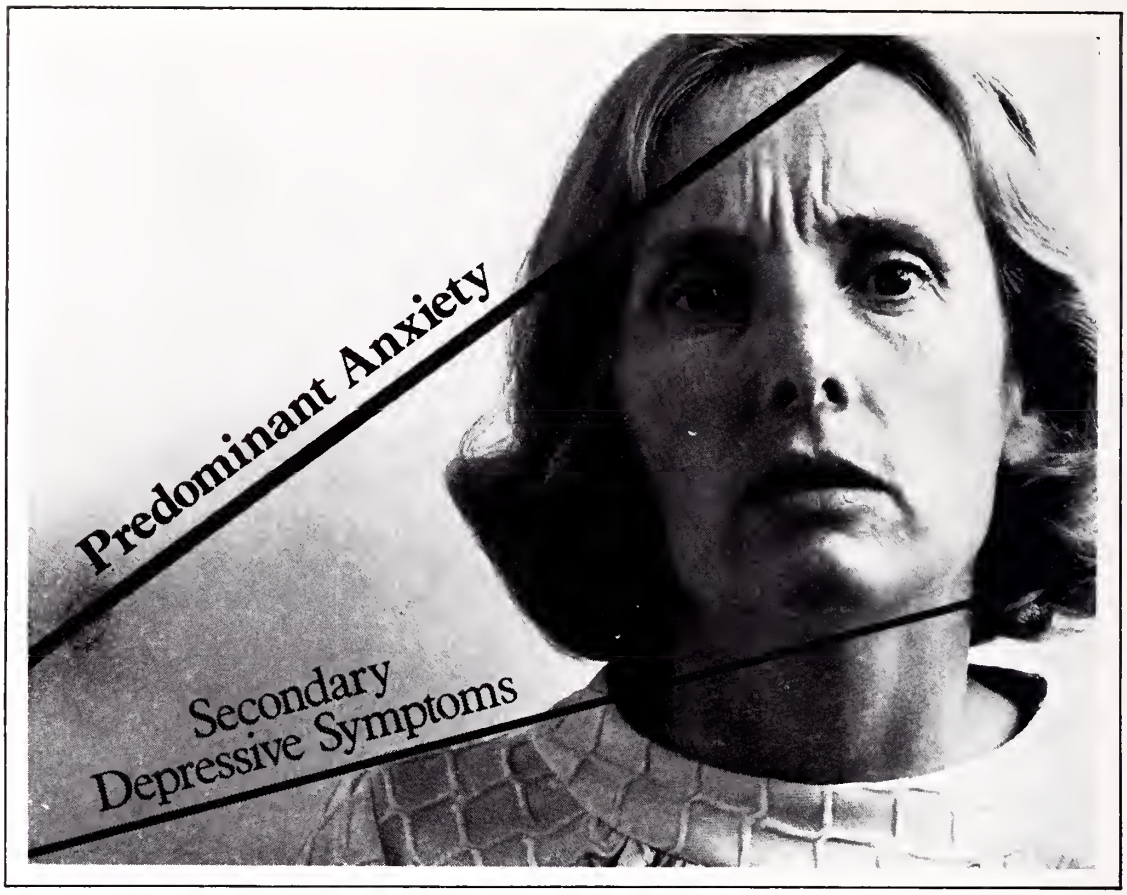

This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex to Valium® (diazepam)

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Valium® 2-mg, 5-mg, 10-mg tablets
(diazepam)

279456
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC. • JANUARY 1974

JANUARY, 1974 • VOLUME 61 • NUMBER 1

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JANUARY COVER—Seal of The Florida Medical Association, Inc.

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President's Page

December 24 — Cocoa Beach

The night before Christmas I sat in my office surrounded by two half bushels of oranges, six jars of jam, a large box of roasted peanuts, three canisters of cookies, a sundry of nondescript children's concoctions, two bottles of whiskey, many Christmas cards with special personal messages such as, "A Christmas thank you to my doctor"; "Doctors should have Christmas too"; "Happy Holidays, Doctor". On reflection, perhaps the practice of medicine hasn't changed; perhaps the personal touch still remains. We all seek fame, fortune and glory as we pass through life, but as I sat there at my desk Christmas Eve, I realized those remembrances, small in value, but big in heart, are what it is all about—whether it is Christmas for the plumber, the banker, the teacher, or the doctor.

As I left my office with misty eyes betraying a grateful heart, tired legs beneath a weary frame, a worried mind concerning two very ill patients at the hospital, suddenly again it all became worthwhile. It's just fun being a family physician and knowing other people really care and have their way of saying "Thank you, Doctor."

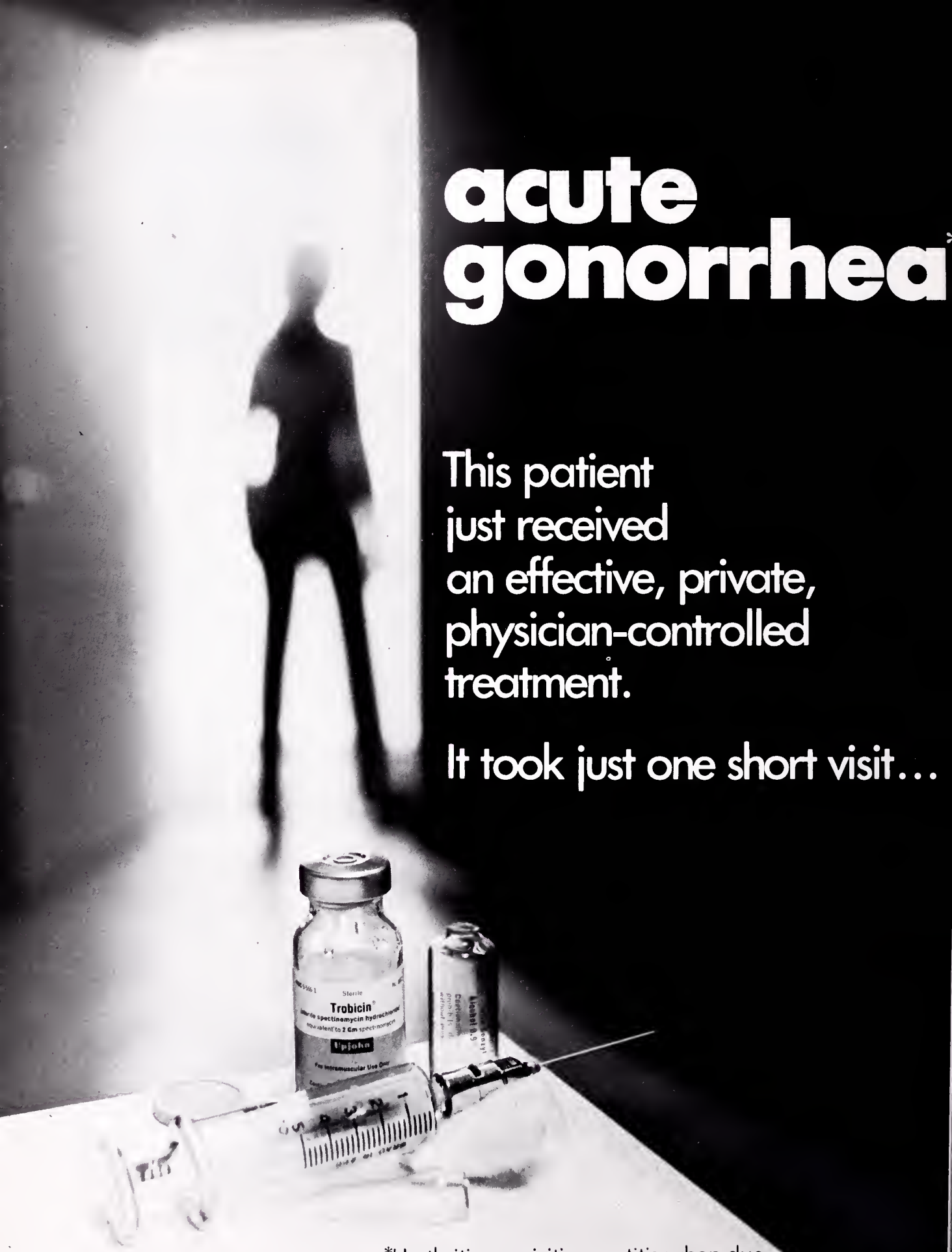
When I think of all the adversities that at times confront our profession, instead of saying "Bah, humbug," I can only wonder if the proponents of the socialized systems with which we are frequently compared really know what the Spirit of Christmas is all about.

I know it is not Thanksgiving Day and I may be a month late, but thank you, God for permitting me to be a doctor, and above all, to be a doctor in America.

acute gonorrhea*

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit...



*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) — For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-I)
The Upjohn Company, Kalamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.

Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

Sequence of therapy— selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

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Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

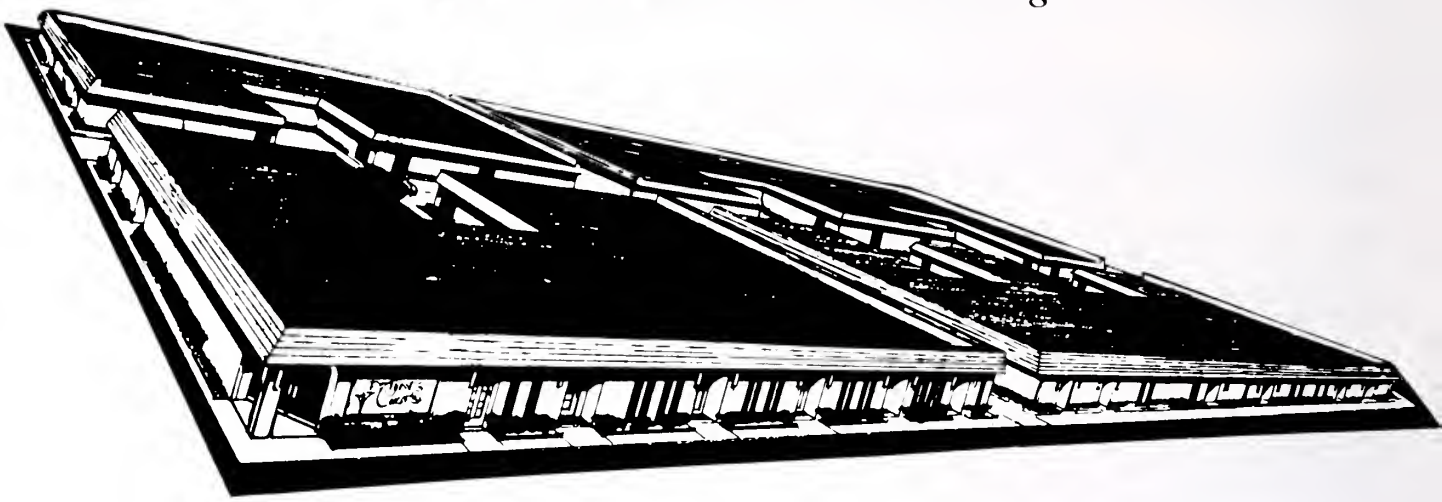
This patient's lesions were resolved with

Efudex®

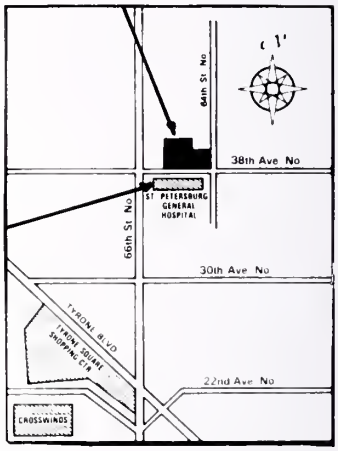
fluorouracil/Roche®

5% cream/solution...a Roche exclusive

Practice Medicine in St. Petersburg



THE 38TH AVENUE PROFESSIONAL CENTER



Pinellas County is growing at the rate of 700 new residents per week. With the County's population already at 600,000+ you can see why this area is in great need for physicians.

Inquire today about a custom office suite with a prestige location by Ted P. Wittner with three acre setting for 40 professionals. Custom designed to your needs from 800 to 10,000 square feet per suite. You receive: (a) your choice of decor (b) carpeting (c) double locked doors (d) individual climate controlled air conditioning (dual systems in 1600 feet or larger) (e) two luxury rest rooms (f) water fountain (g) double ceiling and wall insulation for sound and climate control (h) outside windows in every suite.

(Leases now available for final construction stage)
Call Martin Hirsch

WITTNER & CO.

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3663 Central Avenue **St. Petersburg, Florida**

(813) 896-4638

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

Synthroid®
(sodium levothyroxine)

the smooth road to thyroid replacement therapy.

***Synthroid* is T4.**
It provides your patients with what is needed for complete thyroid replacement therapy.

Free Tab-Minder sample packages available from Flint Professional Services Department.

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

It has been shown that *Synthroid* (T_4) converts to T_3 at the cellular level to supply metabolic needs.[1,2]

1 *Synthroid* is T_4.

2 Because T_4 converts to T_3 at the cellular level, it provides full thyroid replacement at maintenance doses.[1,2]

3 T_4 hormone content is controlled by chemical assay.

4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

5 *Synthroid* provides predictable results when used with current thyroid function tests.

6 *Synthroid* is the most prescribed brand name of thyroid in the U. S. and Canada.

7 Sodium levothyroxine in *Synthroid* tablets is chemically pure. It does not contain any animal gland parts.

8 When stored properly, *Synthroid* has a longer shelf life than desiccated thyroids.

9 On a daily basis, *Synthroid* is cost competitive with other thyroid products.

The smooth road to thyroid replacement therapy.

Synthroid®
(sodium levothyroxine)

most cases with side effects, a reduction of ıge followed by a more gradual adjustment ard will result in a more accurate indication e patient's dosage requirements without the ɜarance of side effects.

age and Administration: The activity of 1 mg. SYNTHROID (sodium levothyroxine) LET is equivalent to approximately one grain ɔid, U.S.P. Administer SYNTHROID tablets single daily dose. In hypothyroidism with-myxedema, the usual initial adult dose is ng. daily, and may be increased by 0.1 mg. y 30 days until proper metabolic balance is ned. Clinical evaluation should be made thly and PBI measurements about every 90 ɜ. Final maintenance dosage will usually ıe from 0.2-0.4 mg. daily. In adult myxedema, ting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

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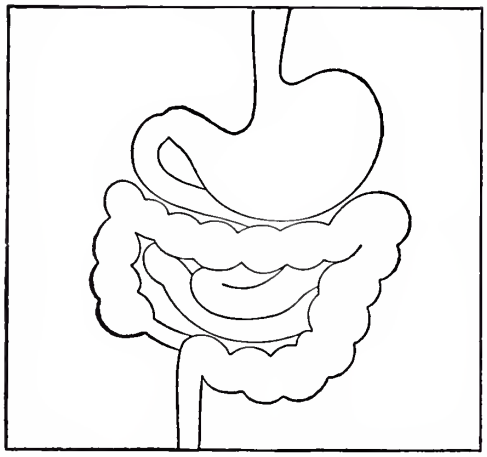
Deerfield, Illinois 60015

in "Gasspastic" conditions



The GI tract in spasm is commonly a "gas trap."

Sidonna® is formulated to release entrapped gas, as well as to provide antispasmodic/sedative effects.

In addition to the traditional combination of belladonna alkaloids and butabarbital (warning: may be habit forming.), Sidonna contains simethicone—a non-systemic defoaming agent that "lyses" gas bubbles on contact.

Sidonna has the ability to relieve GI spasm, pain **and gas** in the irritable bowel syndrome, spastic colon, pylorospasm, gastroenteritis, gastritis, nausea, nervous indigestion, or gastric and duodenal ulcer.

Sidonna can calm GI spasm...control anxiety...and release entrapped GI gas from the system.

Sidonna can do more for your "gasspastic" patient. Try him on 1 or 2 tablets before meals and at bedtime.

Sidonna®

Each scored tablet contains: Specially activated simethicone 25 mg.; hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: May be habit forming.)

can do more

Contraindications: Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.
Side Effects: Dryness of the mouth, blurred vision, dysuria, skin rash, constipation or drowsiness may occur.

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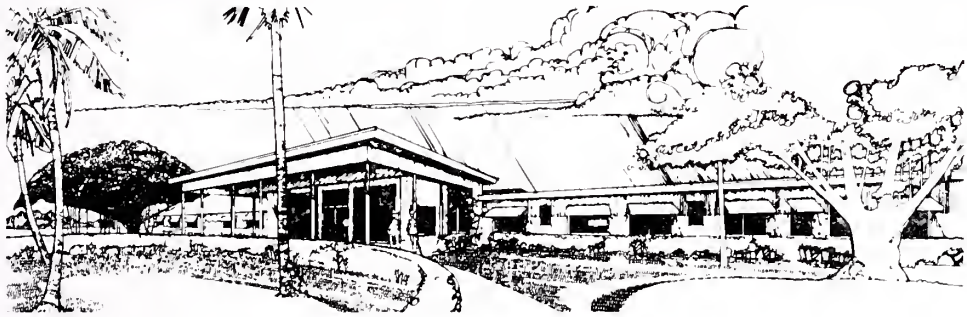

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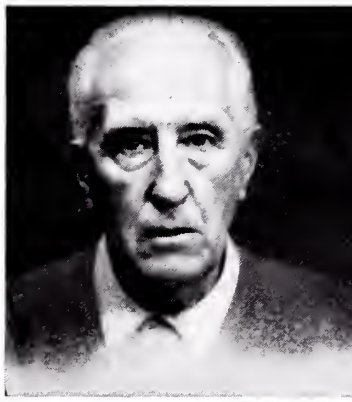

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Menic combines the proven effectiveness of cortical stimulation and cerebral vasodilation, reducing mental confusion, faulty memory and negative social behavior often associated with the senility syndrome.

DOSAGE: Two tablets after each meal.
SIDE EFFECTS: Occasionally flushing and pruritus associated with niacin administration.
PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function, peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.
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The Killers—Trauma

PBS-TV—February 11

8:00 p.m. - 9:30 p.m.

The leading cause of death among Americans under the age of 40, accidents cause approximately 115,000 deaths a year, costing the public more than $23 billion annually.

Accidents on the road, in fires, in the home, on the water, on ski slopes, and elsewhere—and the trauma that ensues—are a major health problem.

And the line between life and death is usually drawn by the emergency medical system closest to the accident victim.

Good emergency care treatment of the trauma victim in this country is spotty, a fact recognized by the American College of Surgeons which has a major program on trauma, and recently a group known as the American College of Emergency Physicians has been formed.

Trauma care requires an area-wide system with cooperation among city officials, hospital staffs, police departments, fire station and citizens, as well as physicians. A few such systems are already proving successful—in Baltimore, Md., Jacksonville, Fla., and throughout the State of Illinois.

However, many more systems need to be put into effect. There is no other medical area where the combination of medical skills, political commitment and community involvement is more closely bound. In the Trauma show of "The Killers," new techniques developed to handle trauma, new institutions created to bring care to its victims, and new community action programs working to improve care are among the subjects to be covered.

Watch for this program on your local PBS-TV.

"...a more satisfactory treatment..."[1]

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500 mg. CAPSULES

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CEVI-BID Capsules permit convenient, b.i.d. dosage for more predictable, sustained vitamin C blood levels all day and night. This avoids the "peaks and valleys" that result from ordinary vitamin C intake (wasteful renal excretions at high levels and less than optimum amounts of vitamin C at low levels). The unpredictability of enteric-coated vitamin C is also avoided. Cevi-Bid's unique micro-dialysis principle provides release of 500 mg. of vitamin C during a 12 hour period at a smooth, uniform rate.

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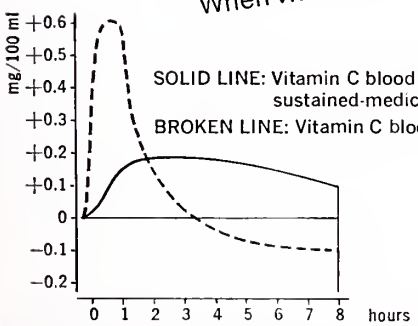

SOLID LINE: Vitamin C blood levels obtained with sustained-medication capsules (CEVI-BID).

BROKEN LINE: Vitamin C blood levels obtained with tablets.

*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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[1] Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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Medical News

Dr. Sherlock

Seminar in Lakeland

Dr. Sheila Sherlock of London, England, currently Chairman and Professor of Medicine, University of London, Editor of the medical Journal GUT and one of the world's leading authorities on diseases of the liver, lectured at Lakeland General Hospital in Lakeland on Tuesday, January 8.

The program was sponsored by the Watson Clinic in cooperation with Warren-Teed Pharmaceuticals.

Dr. Schiebler Honored

Gerold L. Schiebler, M.D., has been named recipient of the Florida Blue Key distinguished faculty award at the University of Florida College of Medicine.

The award recognizes distinguished service to students. In November Dr. Schiebler took a year's leave of absence from the University, where he is Professor and Chairman of Pediatrics, to become the first Director of the new Florida Division of Children's Medical Services.

He is Chairman of the Council on Scientific Activities of the Florida Medical Association.

Dr. Converse Elected

J. Gerard Converse, M.D., of Winter Haven, has been elected President and a member of the Board of Directors of the National Foundation for the Study of Health Science Liability.

The Foundation is composed of physicians, plaintiff and defense lawyers, and representatives of insurance industry and consumer groups.

Vice President of the Foundation is former HEW Secretary Wilbur J. Cohen, now Dean of the School of Education at the University of Michigan.

Heart Course in Miami Beach

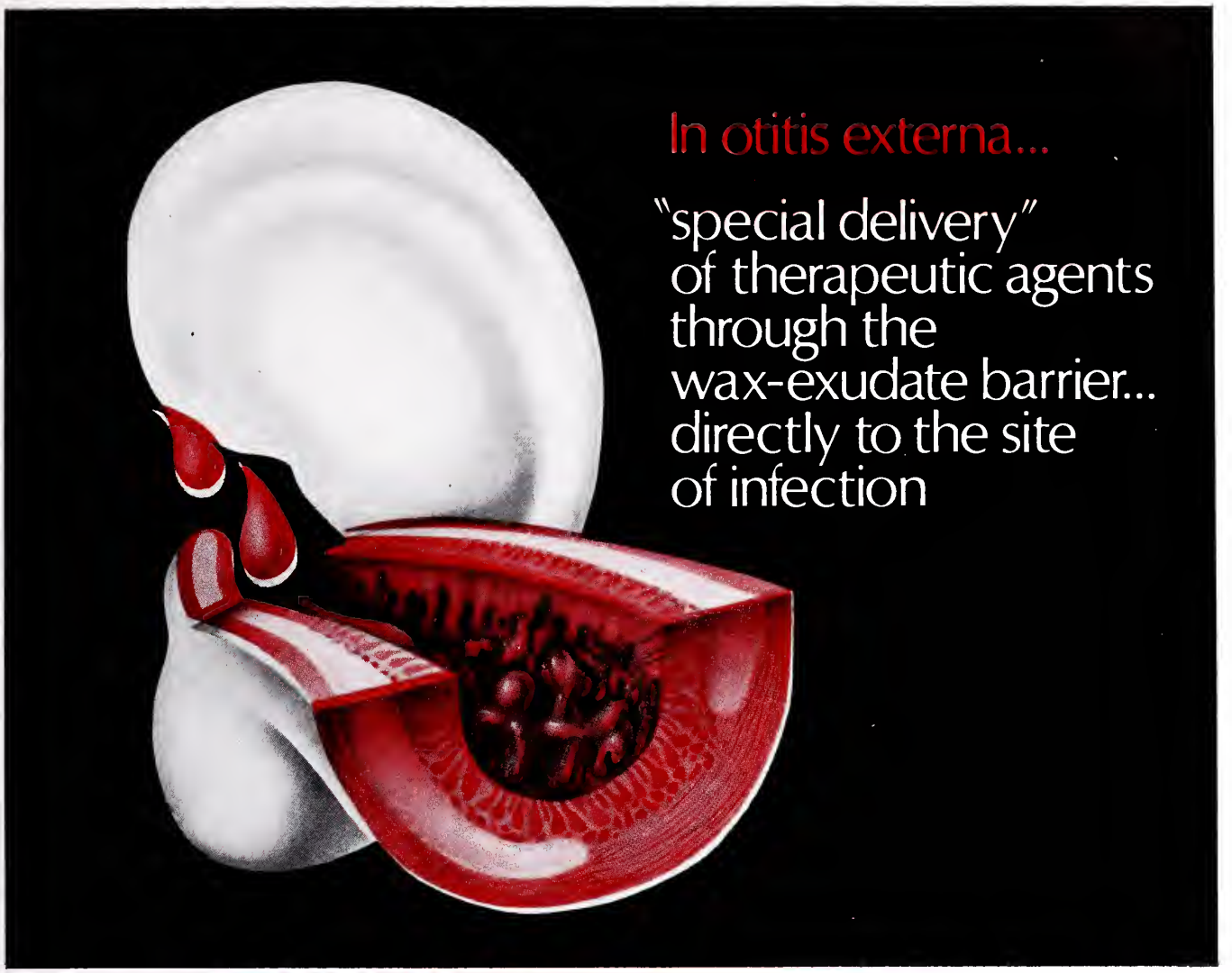
The American College of Chest Physicians has scheduled one of its 1973-74 postgraduate courses for Florida.

A course entitled "Problems in Clinical Cardiology" will be held in Miami Beach, February 25 to March 1 under co-sponsorship with the Mount Sinai Hospital of Greater Miami.

Additional information about this and other ACCP courses may be obtained by contacting Mr. Bradford W. Claxton, Director of Continuing Education, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

Diabetes Association Elects

Carl Moore, M.D., of St. Petersburg, was installed as President of the Florida Diabetes Association at its annual meeting in Miami, October 26-27. John T. Blackburn, M.D., of Melbourne, was named President Elect.



Otalgine Drops

(neomycin undecylenate 0.067%; tyrothricin 0.1%; hydrocortisone alcohol 0.1%; ethylene oxide-polyoxypropyleneglycol condensate 1.0% otic solution)

- ☐ **Antibiotics to combat susceptible bacteria and fungi**
- ☐ **Antifungal action of the undecylenate salt of neomycin against Aspergillus and Monilia**
- ☐ **Hydrocortisone to reduce inflammation and pruritus**
- ☐ **Surfactant-penetrant to deliver therapeutic agents directly to the infected area**

Penetrating the barrier of wax and exudate, OTALGINE Drops bring antibiotics and steroid directly into contact with the infected tissue, with gratifying results against major otic pathogens, including *Pseudomonas aeruginosa, Aspergillus* and *Monilia*. In clinical trials, "Good" to "Excellent" results were reported in 87.8% of 886 cases of otitis externa with 1,149 affected ears.*

BRIEF SUMMARY: Indications: All indications are predicated upon infections due to organisms susceptible to neomycin or tyrothricin, or to the undecylenate salt of neomycin. Otitis Externa (acute and chronic)—Fungal infections (such as *Monilia* and *Aspergillus*). **Contraindications:** Tuberculous and most viral lesions (herpes simplex, vaccinia, and varicella particularly); less common fungal infections (other than *Monilia* and *Aspergillus*); hypersensitivity to any of components. **Precautions:** Use with care in cases of perforated eardrum or long-standing otitis media because of possibility of ototoxicity. As with all antibiotics, prolonged use may result in overgrowth of non-susceptible organisms. If superinfection occurs, appropriate measures should be instituted. There are reports in medical literature indicating increased incidence of persons sensitive to neomycin. **Side effects:** Apparent allergic reactions with such symptoms as crusting, swelling, vesicular rash of the external canal or increase in discharge reported in 1.2% of patients treated; transient warmth or burning sensation on instillation, in 2.7%. **Dosage:** 2 to 5 drops, b.i.d. to q.i.d., or the wick method, with the wick moistened b.i.d. to q.i.d., until disease has cleared or become static. **NOTE:** Refrigerate until dispensed. After opening, keep at room temperature; unused contents should be discarded after 14 days. *BIBLIOGRAPHY AVAILABLE ON REQUEST.

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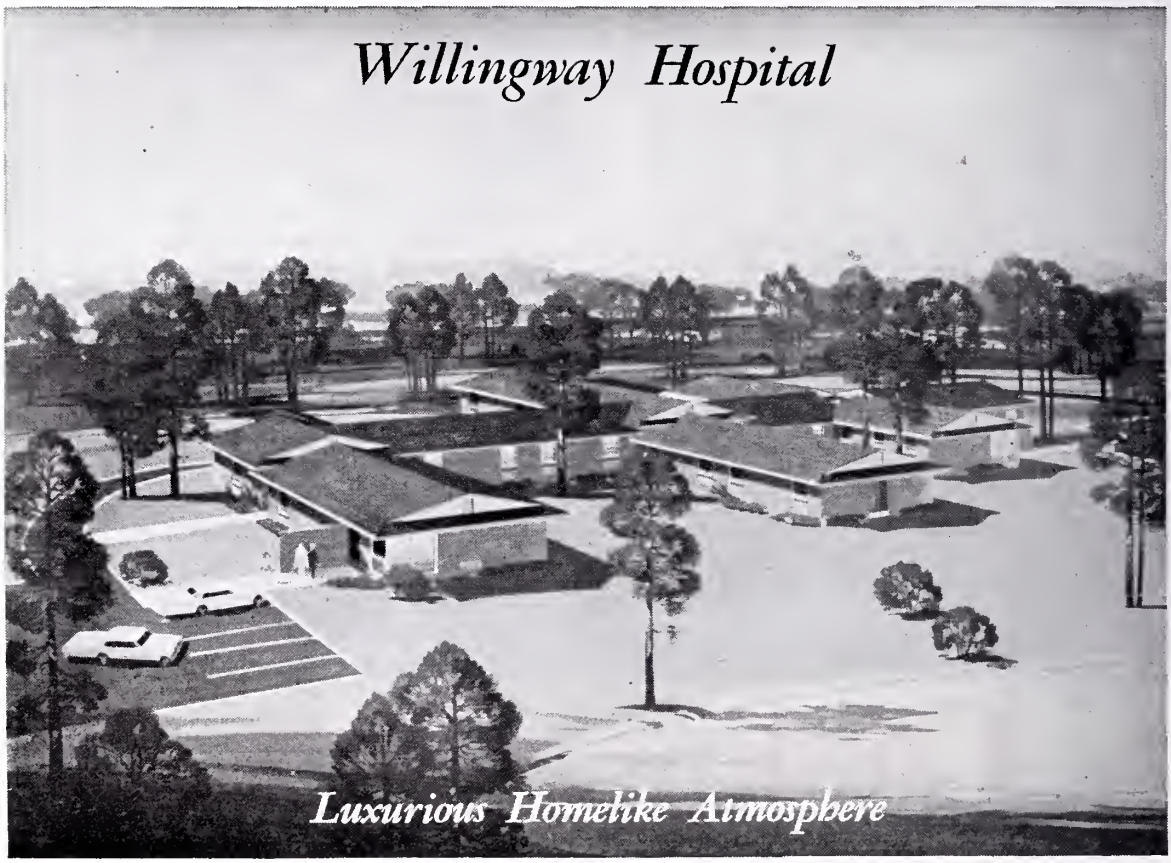

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

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sleep with relative safety

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In most instances when adverse reactions were reported, they were mild, infrequent and seldom quired discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Diz ness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hour without need to repeat dosage

No sleep me cation has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patie given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nig time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to rep dosage during the night.

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Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a zodiazepine specifically indicated for insomnia. It is not a barrate or methaqualone, nor is it related chemically to any other lable hypnotic.

When your evaluation of insomnia indicates the need for a sleep dication, consider Dalmane—a single entity nonnarcotic, nonbiturate agent proved effective and relatively safe for relief of omnia.

DALMANE®
(flurazepam HCl)
When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatolog

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Associatio

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

›int Statement on Antisubstitution Laws and Regulations

The purpose of this statement is affirm the support of the participat- g organizations for the laws, regula- ›ns and professional traditions which ohibit the unauthorized substitution drug products.

Traditionally, physicians, den- sts and pharmacists have worked ›operatively to serve the best inter- ›ts of patients. Productive coopera- ›n has been achieved through utual respect as well as a common ›ncern for the ideals of public ›rvice. This mutual respect has been ›flected, in part, by joint support ›er the years for the adoption and ›forcement of laws and regulations ›ecifically prohibiting unauthorized ›bstitution and encouraging joint scussion and selection of the ›urce of supply of drug products. ›e basic principles of medical, den- ›l and pharmacy practice are thus ›ilized and preserved in the interest patient welfare.

The antisubstitution laws have ›t obstructed enhancement of the ›ofessional status of pharmacy any ›ore than they have in and of them- ›lves guaranteed absolute protec- ›n from unsafe drugs, or freed ›ysicians, dentists and pharmacists om their responsibilities to patients. s a practical matter, however, such ›ws and regulations encourage inter- ›ofessional communications regard- ›g drug product selection and assure ach profession the opportunity to ›ercise fully its expertise in drug sage, to the advantage of patients.

Physicians and dentists should e urged to increase the frequency nd regularity of their contacts with harmacists in selection of quality rug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION, INC. • JANUARY 1974

Three Score Years

A medical journal is a unique transmission belt supplying the doctors of today with the wisdom of the past in order to safeguard the potential of the future. And for more than half a century this has been the sole intent of those involved in publishing *The Journal of the Florida Medical Association,* their only regrets having been that restraints of space, time and money limit the amount of original material appearing each month. Some of these restraints have been lifted for this Centennial issue which is undoubtedly the result of more man-hours spent in researching, composing, editing, typing and retyping than any two or three of the previous 716 issues. Most of the credit should be given to Bill Straight of Miami and the many contributors. In assisting them, it has been stimulating to browse through past FMA Proceedings and leaf through copies of old journals, to relive in the mind's eye the early days of the Association in 1874, 1879, 1914, and on. It's easy to develop empathy and admiration for those who worked in the forefront of organized medicine during the past 100 years. Their problems have changed but little over the years. Neither have the ideals or dedication of each incoming president who, giving his annual address, displayed his inner convictions, his sense of devotion to his profession and his sense of duty to his patients. Physician involvement, communications, continuing education and government intervention have been and still are recurring problems that can't be solved once and for all, but with unending effort, must be coped with over and over by each new slate of officers backed by each new generation of doctors. Old issues of *The Journal* attest to the course of the Association as putting first the best interest of the patient under the guidance of our elected officers, not always a popular tack.

Now with magnetic tapes, two-way cable TV, computers and the newer data retrieval systems, will there be a need for *The Journal* in the next 40 years? With the time lag in getting ideas and thoughts onto paper from the mind of the physician author in a laboratory or a private office and then to the printer for publishing, the medical newspaper appears to be taking the place of *The Journal.* There appears, however, to be a need for some medium where philosophical views can be expressed and experiments and scientific articles can be preserved for the reader to reflect on and absorb at his leisure. A state *Journal* is needed as a repository for official business and proceedings, and diseases and epidemics and methods of treatment peculiar to its geographic location. There also must be some facility for recording the unusual experiences of private practitioners who do not have a medical school prestige to provide an outlet. Finally, where else will the chronicle of current medical events be so painstakingly recorded and accurately described as in an official *Journal?*

Progressing from bloodletting to blood banks to organ (and skin) banks and from eradicating the causes of yellow fever and smallpox to polio, having eradicated diseases 40 years from now that plague us today, *Journal* readers will have to speak up and assert themselves in support of the responsibilities and rights of the practicing physician. While it is futile to predict what medical practice will be like when *The Journal* is 100 years old in 2014, there is one thing that will remain basic: The one-to-one doctor-patient involvement, the need to listen to a patient's story, to examine him and to develop a relationship of supporting reassurance that his doctor cares and will do all in his power in assisting the patient's return to normal living.

The Journal, as an institution and a method of communication, has a life of its own, and this will go on only because of its continued usefulness to its readers. To this continued usefulness, future editorial staffs must dedicate the 479 remaining issues of the next 40 years, while to our past presidents, and other elected officers, the many Houses of Delegates and to all those men producing the history of Florida medicine who have made the Florida Medical Association what it is today, we dedicate this Centennial issue.

C.MC.

Florida Medical Association The First Seventy-Five Years

WILLIAM M. STRAIGHT, M.D.

On January 14, 1874, in response to an invitation sent by the Duval County Medical Society in November, 1873, ten physicians met at the "commodious" home of Dr. Abel Seymour Baldwin on the corner of Laura and Adams Streets in Jacksonville. These physicians from seven cities and towns met for the purpose of organizing a medical society for the State of Florida. As reported elsewhere in this Centennial Issue, an unsuccessful attempt to accomplish this purpose had been made in 1848-1849 at Quincy, Florida.[1] This, the second attempt, was to be successful and the charter membership of 25 was to grow over the next century to more than 8,500.

Those present at the initial meeting were:

Abel Seymour Baldwin, Jacksonville, Duval County Society

George W. Betton, Tallahassee, Leon County Society

Richard B. Burroughs, Tallahassee, Leon County Society

T. W. Carter, Lake City, Columbia County Society

E. G. Clay, Fernandina, Nassau County Society

Richard P. Daniel, Jacksonville, Duval County Society

M. M. T. Hutchingson, Lake City, Columbia County Society

Thomas P. McHenry, Newnansville, Marion County Society*

John E. Peck, St. Augustine, St. Johns County Society

Francis Preston Wellford, Jacksonville, Duval County Society.

These ten elected to membership another 15 physicians known to them making the total of 25 charter members. Although each of these men appears in the minutes of the original meeting as representing a county medical society, as near as can be learned at this time, only the Duval County Medical Society (founded in 1853) was a functioning society. The Marion County Society had been organized in 1867 but soon ceased to exist and was reorganized in 1888. The Pensacola Medical Society (Escambia County Medical Society since 1903) had been organized in 1873 but sent no representative to the initial meeting.

*McHenry is listed as representing the Marion County Medical Society but on all maps of that period available to this author, Newnansville is in Alachua County.

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. . . at the commodious home of Dr. A. S. Baldwin, 1874.

At this founding meeting the following business was accomplished: a name was chosen, "The Medical Association of the State of Florida"; the Constitution and By-Laws of the Medical Association of Georgia were adopted until a committee appointed by the president could draw up a suitable Constitution and By-Laws; and officers were elected: A. S. Baldwin, President; G. W. Betton, First Vice President; Robert Harrison, Second Vice President and F. P. Wellford, Secretary and Treasurer.

In this day of superhighways and jet air travel, assembling ten physicians from diverse parts of the state is readily accomplished. In 1874 it was quite another matter for money was scarce and travel difficult. Betton, Burroughs, Carter, Hutchingson and McHenry probably traveled on the Florida Atlantic and Gulf Central Railroad which could make a top speed of 35 miles per hour over the best section of its track (Quincy to Lake City). Clay likely rode the Florida Railway which had a top speed of 15 miles per

hour as the soft English steel of its pre-Civil War tracks tended to warp upwards at the rail junctions, making "snakeheads" which would derail a faster moving train.[2]

One must admire the dedication of these men as did Robert Drake Murray, a Key West physician who had a national reputation as a yellow fever expert and who became the fifth president of the FMA. In addressing the annual meeting of 1876, he commented:

> It is a wonderful sight to see men, few of whom have time or means to leave their homes for even business purposes, congregating at great personal expense to deliberate upon matters for the relief of untoward conditions of people and society, when the results of those deliberations are to apparently operate against the interests of the deliberators. Scattered, as we are, over a large State having poor and costly traveling facilities, and in the midst of stringent times, we certainly deserve more than a passing notice, if not great commendation, for thus assembling.

Second Annual Meeting

At the second annual meeting, Jacksonville, February, 1875, there were 12 present to act on the presented Constitution and By-Laws. This document gave the name of the organization as "The Florida Medical Association" and stated its objects:

> The object of this Association shall be to organize the Medical Profession throughout the State in the most efficient manner, to promote union, harmony, and good feeling among the members, to establish and maintain a high standard of professional acquirement, and ethics, and to inspire interest and zeal for the cultivation of medical science and literature.

It provided for: three classes of membership, officers, four committees (Publication, Accounts, Arrangements, and Ethics), an annual meeting, and an annual assessment of $5 payable at the annual meeting. To be eligible for membership physicians must be "regular graduates of some reputable medical college. No graduate who practices a special system of medicine (i.e., Homeopathy or Eclectic) shall be admitted." He must also be a member of a county society, if one existed within 20 miles of his residence. Each county society was entitled to send two delegates to the annual meeting. If no county society existed and if there were four or more physicians in the county, they could send one delegate elected by a majority vote of the physicians in that county. The president was empowered to appoint delegates to the American Medical Association, and the Code of Ethics of the AMA was to govern the conduct of FMA members.

The first application for incorporation was made to the legislature of 1878, but the press of other business resulted in no action until the following year. Again in 1917 and most recently in 1926, the FMA has been incorporated under the laws of Florida.

From its inception the FMA has sent delegates to the AMA but for many years FMA members were not always members of the AMA. In 1892 a resolution was adopted instructing the secretary to send a roster of the dues-paid FMA members to the AMA. This made FMA members eligible for membership in the AMA.

Membership

Initially, to become a permanent member of the FMA, a physician who met the requirements had to be proposed by a FMA member in good standing and be approved by a three-fourths vote of the members present at the annual meeting. A physician might become a member for a single annual meeting by appearing as a duly elected delegate from his county society and paying the $5 assessment. The first mention of a Membership Committee appears in 1888 apparently in response to a situation in which a member, who was also in the State House of Representatives, embarrassed and angered many of the FMA members by ill-conceived and independent action in the legislature.

As the philosophy of "regular" physicians throughout the country became more liberal, and the leaders of the AMA began a reorganization movement intent on enrolling every reputable physician in a county-state-national organization, the FMA membership requirements were accordingly changed. In the 1898 By-Laws the bar to Homeopaths and Eclectics was lowered, if they would agree to practice nonsectarian medicine: ". . . every reputable, white and legally registered physician who is practicing, or will agree to practice, non-sectarian medicine shall be entitled to membership." Black physicians were not yet eligible. The first proposal for membership of a black physician was in 1893. G. W. Betton proposed G. W. Gunn of Tallahassee, but this was tabled. Not until 1950 was the word "white" stricken from the membership requirements. The first female physician to become a member seems to have been Harriet E. Preston of St. Augustine. She was elected to membership in 1889, appeared on the active roster of 1892 and then is lost sight of. Our present Constitution and By-Laws leaves up to the component county society the requirements for membership. Membership certificates

. . . at the San Juan Hotel, Orlando, 1900. (courtesy of State Photographic Archives, Strozier Library, Florida State University)

were first issued in 1892 and membership cards in 1927.

In the first 30 years of its life the FMA grew from 25 members to 170 with ups and downs along the way. Then began a vigorous effort to recruit members and organize county societies in line with the AMA reorganization drive of 1901. By this time the AMA had gone so far as to declare it the right of every ethical and knowledgeable physician of good moral character to be a member of his county-state-national societies regardless of sectarian background.[3] Over the next ten years the FMA membership more than doubled and since it has continued to climb with dips during economically depressed times.

The initial annual dues were $5 but in 1893, due to a surplus in the treasury of $717.82, they were reduced to $3. Soon rising expenses forced the dues to $10 annually where they remained until the early 1930's when, hoping to stave off a loss of members, they were reduced to $7.50 for three years. As times improved the dues were returned to $10 and from that point they have continued to climb.

Changes in the Constitution and By-Laws

The first published complete revision in the Constitution and By-Laws appeared in 1898. At this time the name appears, "The Florida State Medical Association."* The objects and purposes are expanded to include: Elevation of the standard of medical education, enactment and enforcement of just medical laws, guarding the material interests of the members, and enlightening the public on "the great problems of State Medicine."** This document provided for division of the state into eight councilor districts. This number was increased to 21 in 1925 and then reduced to four in 1960. The councilor of each district was elected at the annual meeting and was to be "an organizer, peacemaker and censor." At each annual meeting the councilors sat as a body to promote the organization of county societies, issue charters to county societies, and handle grievances from the membership. In this revision for the first time a House of Delegates is mentioned and each county society is entitled to one delegate for every 20 members or part thereof in the county society (later the word "major" was inserted before the word "part"). To pressure the county society secretaries into submitting the collected dues and their annual reports more promptly, in 1919 an amendment was adopted that societies could be

*In the published Constitution of 1923 and thereafter the name appears as The Florida Medical Association, Inc.

**The term "State Medicine" referred to what we today accept as the proper activities of the public health departments.

represented only to the number of their dues-paid members and only if the secretary's report and monies were in the hands of the FMA secretary/treasurer at least 30 days prior to the annual meeting.

Administration and Housing

In the early days of the Association the elected secretary served as stenographer and record keeper and the elected treasurer as business manager and bookkeeper. The office of secretary was made a permanent office in 1884 and A. W. Knight served in this capacity until his death in 1890. In 1886 a similar amendment made the office of treasurer a permanent assignment and John Domingo Fernandez, incumbent since 1878, continued as the treasurer. With the death of Knight, Fernandez was made secretary/treasurer, a position he held until his death in December, 1913. Merritt credits Fernandez' ". . . untiring efforts, his ability as an organizer, and his widespread popularity . . ." with sustaining and nurturing FMA through the difficult early years.[5]

By 1926 the demands on the secretary/treasurer had become so heavy that a resolution was adopted to hire a part-time business manager. Stewart Gordon Thompson, D.P.H., Director of Vital Statistics of the State Board of Health, was employed and rapidly proved his worth in getting the affairs of the Association on a business-like basis. In 1937 he became the full-time managing director and served the Association faithfully until his death in 1953. Following Thompson's death, Ernest R. Gibson and more recently W. Harold Parham have served in this capacity.[4]

Prior to the advent of Stewart Thompson, the society's records were kept at the home of the secretary. Indeed, the devastating fire in Jacksonville on May 3, 1901, destroyed the home of J. D. Fernandez and with it all the books, accounts, reports and papers and the seal of the FMA. Through the efforts of Thompson and Webster Merritt gradually a complete file of the FMA Proceedings/Transactions/Journal was reassembled.*

When Thompson began as business manager, a room was rented in the State Board of Health building as the headquarters of the FMA. SBH clerical personnel were hired as needed and given overtime pay to keep the records. In 1932 this office was moved to the Florida Theatre Building where sufficient space was available for $15 per month. At this time the first full-time stenographer was employed. Finally, the presently owned land on the St. Johns River in downtown Jacksonville was purchased and a permanent building completed in 1956.

House of Delegates

As we have previously noted, initially the voting delegates were two members from each county society and one member from each county containing four or more reputable physicians but which had no medical society. Later each component society in good standing was permitted two delegates for every 20 members or major part thereof. More recently the ratio has been lowered to one delegate for every 40 component society members and the privilege of the floor has been extended to certain other FMA members.

At the early meetings, indeed, up until 1940, the House transacted its business as a committee of the whole. However, the amount of business and its complexity increased to the point that this

Stewart Gordon Thompson, FMA Managing Director, 1926-1953.

*The published record of the FMA was known as "The Proceedings of the Florida Medical Association" until 1899 when, without apparent official action, it was changed to "The Transactions of the Florida Medical Association." With the publication of the Journal of the Florida Medical Association, beginning July, 1914, the previous names disappear except that each annual meeting is recorded in the JFMA as "The Proceedings of the . . . . . Annual Meeting of the FMA."

method became cumbersome and of questionable effectiveness. In that year our fraternal delegate to the Medical Association of Georgia, Gerry Rounds Holden, brought from them the Reference Committee format we now use. The Delegates Handbook was added in 1947 although possibly loose mimeographed sheets were used prior to that date. Until the session of 1961 it was customary for the president or one of the vice presidents to preside over the House. In 1961 the Speaker/Vice Speaker system began.

Election of Officers

Although the early editions of the Constitution and By-Laws provide for a Nominating Committee, a review of the meeting minutes indicates the practice was to nominate the officers from the floor of the General Assembly or House. Initially, all members present at the annual meeting voted on the officers but the 1898 Constitution states that officers were to be elected by the delegates. Although no specific official action seems to have been taken, in the 1923 Constitution they are again to be elected by the general assembly. In 1947 Walter C. Jones introduced an amendment requiring that the officers be nominated and elected by the House. As he pointed out, the society had grown so much that only a few metropolitan areas could accommodate the annual meeting and since the host area usually had the largest number of members attending, they might well control the election. Thus, our present By-Laws clearly state that the officers shall be elected by the House where each county society has proportionate representation.

Initially the principal elected officials were: President, two Vice Presidents, Secretary and Treasurer. Later a third Vice President and eight Councilors and Delegates to the AMA were added and the offices of Secretary and Treasurer combined. In 1933 the office of President-Elect was instituted, and in 1960 the offices of Speaker and Vice Speaker.

Executive Committee and Board of Governors

At the beginning, business which had to be transacted between annual meetings of the Association was taken care of by the president and/or the secretary with advice or help from whomever they consulted. In May, 1915, an "Advisory Committee" was instituted for the purpose of attending to Association's business between the annual meetings. Members of this committee were: the president, secretary, and three members chosen by the president. At the meeting of 1917 this committee made a report as the "Executive Committee." It seems this committee quickly "felt its oats" for in 1917 it recommended to the House that the House abolish itself and let all business of the Association be handled by the Executive Committee. This did not fall on sympathetic ears, but it was proposed again in 1920 and again rejected. The Board of Governors is first mentioned in April, 1942. Today's Executive Committee is the liaison, investigative and planning arm of the Board of Governors and reports to the Board which serves as the administrative body between annual meetings.

Annual Meetings

With the single exception of 1945, since the founding of the FMA, meetings have been held annually. The exception was occasioned by a last minute ban on conventions (February to October, 1945) imposed by the Office of Defense Transportation to reduce the railroad usage and gasoline consumption during World War II. Attendance at the early meetings was scanty for reasons we have previously discussed and was largely comprised of members from the host city. Usually the attendance at meetings in Jacksonville was better partly because the railroad connections were better and partly because of the large number of FMA members in the Jacksonville area. In 1881

. . . at the San Carlos Hotel, Pensacola, 1921.

the meeting in the Senate Chambers at Tallahassee had to be adjourned after the President's Address, election of two physicians to membership, and the election of officers, as none of the committee chairmen or speakers were present. When the appointed hour arrived for convening the session in Pensacola in 1882, so few were on hand that the meeting was adjourned and reconvened 48 hours later. In the Pensacola Weekly Commercial, April 21, 1882, appears the following item:

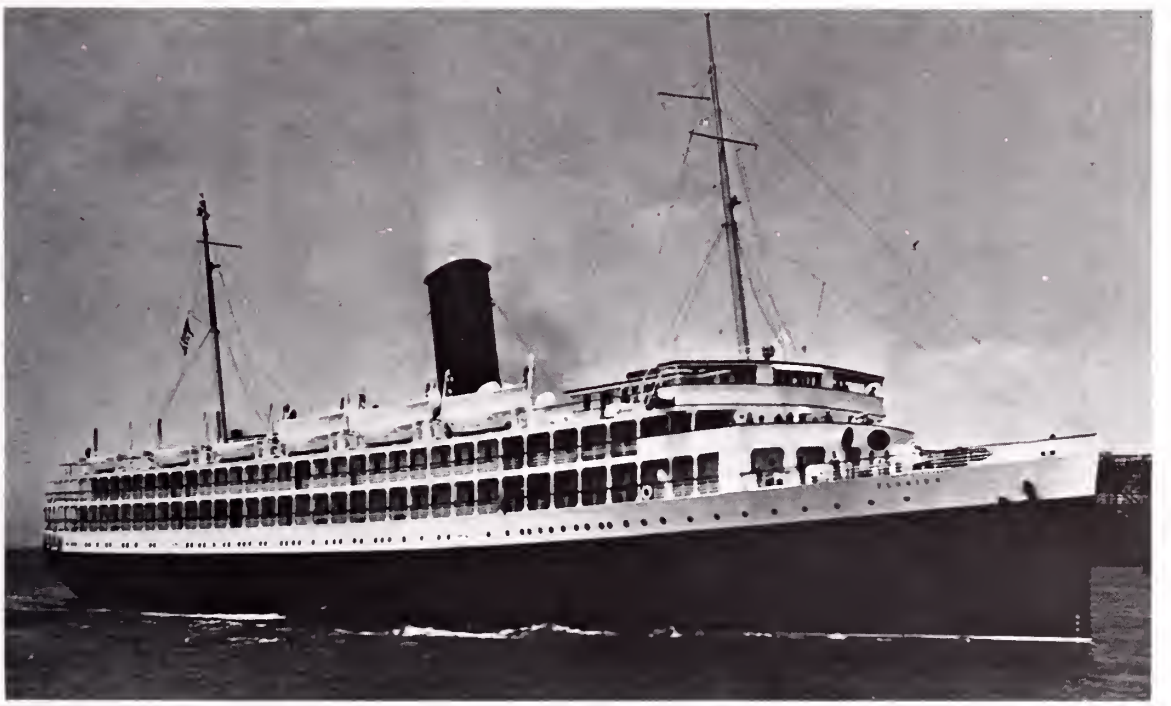
PROCEEDINGS OF THE BOARD OF HEALTH

The following resolution offered by Mr. D. G. Brent, adopted: That, inasmuch as the gentlemen comprising the Florida Medical Association failed to appear in sufficient numbers to justify the expenditure of the money, raised by subscription for their entertainment, under the auspices of the Board of Health (only one member being present): therefore be it Resolved, That Drs. Hargis, Whiting and Fordham, constituting the subscription committee, be, and they are hereby instructed to refund to the subscribers, with the thanks of the Board, the money respectively collected by them.

In an effort to stimulate statewide interest the FMA meetings were held in various places as determined by a vote at each annual meeting. Thus over the years they have been held at: Jacksonville, Tallahassee, Pensacola, Sanford, Palatka, St. Augustine, Gainesville, Ocala, Key West, Tampa, Orlando, Live Oak, Miami, DeLand, Arcadia, Atlantic Beach, Daytona and Daytona Beach, St. Petersburg, West Palm Beach, Sarasota, Hollywood Beach, Belleaire, and Miami Beach.

As early as 1893 Sheldon Stringer of Brooksville recommended that the annual meeting settle down at "one central, convenient, commodious and cheerful point" and stop peregrinating about the state. He noted that development of railways throughout the state had made travel easy and "comparatively cheap." Despite this recommendation the meetings continued to peregrinate and, indeed, on three occasions were held en route to or in Havana, Cuba (1892, 1922, 1936). By 1938 the large attendance at the annual meeting was noted as causing increasing difficulty in finding suitable hotel accommodations. However, the meetings did not settle down until after the 1960 meeting in Jacksonville. Since that time it has alternated between Bal Harbour (Miami Beach) and Hollywood Beach where the facilities are adequate to handle the attendance.

Two addresses were certain at the early meetings, the president's and that of the orator selected by the president at the previous meeting. Either or both of these might be devoted to the state of the profession, the condition of the FMA, the history and/or philosophy of medicine, or a scientific presentation. With the passage of years increasing numbers of scientific papers were offered and guest speakers, sometimes of national reputation, ap-



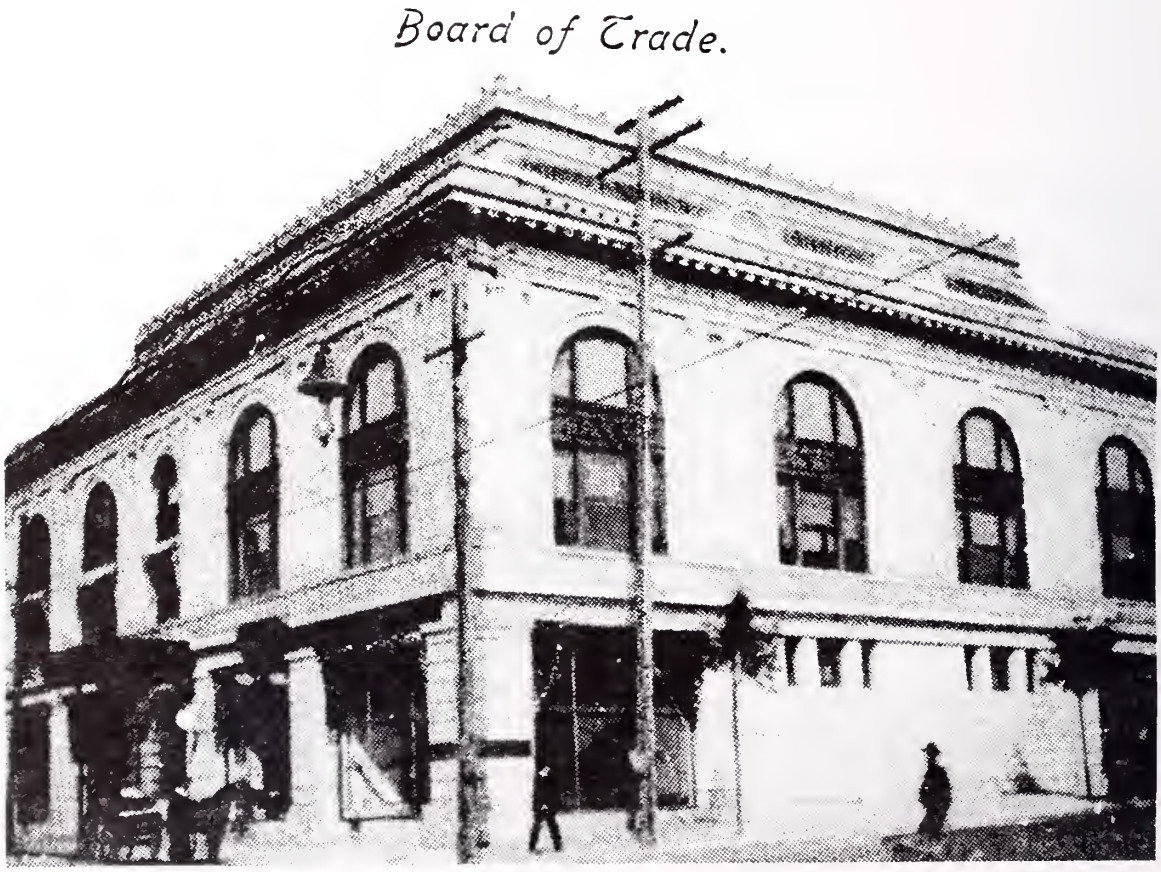
. . . aboard the S.S. Florida enroute to Havana, 1936. (courtesy of E. A. Mueller and The Mariners Museum, Newport News, Virginia)

peared on the program. One such guest in 1922 gave a paper entitled "The Carbohydrate Diathesis" which provoked violent condemnation from the floor and a motion that it not be published in the Journal. With such a benign title it is difficult to imagine how the speaker could make inflammatory comments.

At first no time limit for presentation and discussion was imposed but as the demand for space on the program became greater the By-Laws were amended such that no speaker could present more than 20 minutes and no discussant could speak for more than five minutes and only one time on a given subject. For a period of years, all papers had to be read before the county society before they would be accepted for the program of the annual meeting.

From the very beginning all papers presented at the annual meeting and given to the secretary/editor were printed in the Proceedings/Transactions/Journal.

In April, 1879, the scientific program was enriched by the demonstration of live germs under a microscope in the lecture room. This accompanied a paper entitled "The Germ Theory of Disease" by C. J. Kenworthy. Although today possibly no one would stop to peer through the microscope, one must recall that many practicing physicians and some professors in prominent medical schools did not accept the microorganismal cause of disease in those days. "Plates" as illustrations of a talk are mentioned in connection with a paper on dengue fever by R. B. Burroughs at the session of 1885. He speaks of ". . . a liver of a boxwood or straw color, as represented by these plates taken just after death by Dr. Arnold . . ." One would suspect these were photographs circulated in the audience as there is nothing mentioned to suggest projection. The first mention of lantern slides appears to be in 1905 when a guest from Brooklyn, N. Y. presented "an interesting stereopticon lecture on pathologic diagnosis." The Association had to pay $19.50 to rent the stereopticon for that talk. In the late 1920's the printed program increasingly carries the notation "with lantern slides" after the title of a paper.



Board of Trade Building, Jacksonville, site of many FMA meetings. (courtesy of State Photographic Archives, Strozier Library, Florida State University)

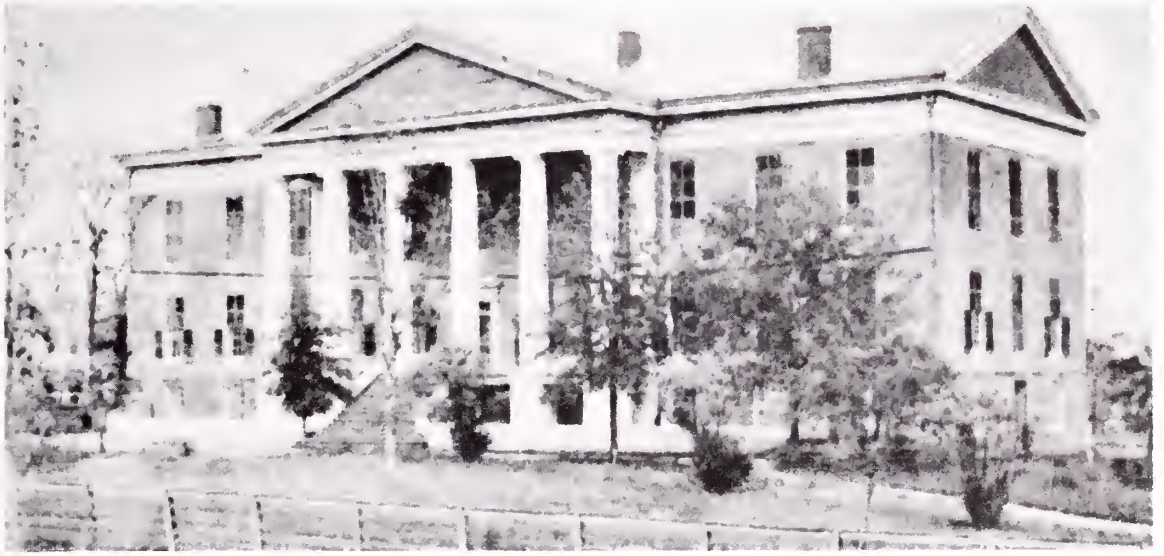
Motion pictures are first mentioned as accompanying a paper on the "Hygiene of Swimming" presented by H. Marshall Taylor at the Sarasota meeting, May, 1932. Closed circuit television was first available at the 1957 session and by courtesy of Smith, Kline and French Laboratories.

State Board of Health Legislation

The first major legislative project undertaken by the fledgling FMA was to seek the establishment of a State Board of Health. Under the territorial government boards of health with local jurisdiction were established at Pensacola and St. Augustine, but nothing had been done in this regard since. Epidemic diseases, particularly yellow fever, had ravaged the state biennially for a century with much economic loss, suffering and loss of life.[6] Other states had already established boards of health and there was talk of a National Board of Health. At its second annual meeting the FMA adopted a proposed SBH bill and appointed a committee, headed by John P. Wall, a well known Tampa physician, and R. D. Murray, to present it to the legislature. Wall also attempted to stir up popular support by an article in a lay magazine in which he said, "The duty of preserving the health and lives of its citizens from the causes of disease is as incumbent on the State as is that of suppressing rapine and murder."[7] He goes on to urge a State Board of Health with power to demand the registration of births and deaths, the reporting of epidemic diseases, and the enforcing control measures.

Such legislation had been proposed in 1873 but defeated because it requested the "exorbitant" appropriation of $200. By the legislative session of 1876 the ante had gone up and the bill proposed by the FMA requested an appropriation of $1,500. Action on the FMA's proposal was "postponed indefinitely." The 1881 session of the FMA was convened in mid-January in the Senate Chambers at Tallahassee and the public invited with the hope of getting the ear of the legislators, many of whom were in the capital for the annual legislative session which was about to convene. President C. J. Kenworthy gave an impassioned address upon the urgent need for a SBH, but again to no avail. This was a period of rigid economies in the state government[8] and although both Governors Drew and Bloxham asked for SBH legislation the best that could be had was a law in 1881 requiring the governor to appoint a Board of Health for each incorporated town of more than 300 voters.[9] The Constitution of the State of Florida adopted in 1885 did provide for a SBH and "county boards of health in all counties where it may be necessary" but no appropriation was forthcoming.

Thirteen years and nine outbreaks of yellow fever, one with 2,350 cases and 197 deaths, passed and again SBH legislation was defeated. R. B. Burroughs, perennial chairman of the FMA legislative committee, defeated by the intransigence of the legislators and disgusted by an ill-advised move on the part of an FMA member in the House of Representatives, submitted his resigna-



. . . in the Senate Chambers, Tallahassee, 1881. (courtesy of State Photographic Archives, Strozier Library, Florida State University)

tion. Even the persevering Wall stated his belief that it was hardly worthwhile and beneath the dignity of the FMA to continue pleading with the legislators for a SBH.

However in August, 1888, a most devastating yellow fever epidemic broke throughout the state. In Jacksonville alone there were 4,696 cases with 430 deaths between August 10 and December 5.[6] Commerce was paralyzed, fear and panic were rampant, and political campaigning (it was an election year) all but impossible. At county borders roads and railroads were blocked by armed vigilantes demanding certificates of health from the candidates or refusing them entry. Finally, something had to be done! As one of his first official acts, the successful gubernatorial candidate, Francis P. Fleming, called a special session of the legislature (February 5, 1889) and obtained the SBH legislation and appropriation so long pursued by the FMA. The members of the board were speedily appointed, Joseph Yates Porter chosen State Health Officer, and the SBH organized. To avoid conflicting authorities the 1893 legislature abolished all of the autonomous county boards of health except those of Escambia and Franklin Counties. In 1894 the Franklin County board ceased and, finally, in 1897 the Escambia board was abolished leaving the SBH with undisputed authority throughout the state. During the 85 years of the SBH existence the FMA has often gone to bat with the legislators who would curtail its authority or funding.

Medical Practice Act and Medical Examining Boards

A second early legislative goal of the FMA was an act defining who shall be permitted to practice medicine in Florida and providing an examining board to judge the qualifications of applicants for medical licenses. Elsewhere in this issue are the details of medical practice legislation prior to the advent of the FMA.[1]

When the FMA appeared on the scene there were many ill-trained and bogus physicians in practice. At the annual meeting of 1878 a committee began work toward a suitable medical practice act. Their efforts met with repeated rebuffs and accusations that the FMA was trying to set up a medical trust. In 1881 the legislature did respond by setting up six medical examining boards in major cities throughout the state.[10] These were autonomous boards[10] and could examine only "regular" physicians due to the rigid AMA Code of Ethics of that period which forbade regular physicians from sitting on a board with or signing the certificates of irregular (Homeopathic and Eclectic) physicians. In the next several years it became obvious that this system was vulnerable to many abuses. In an effort to overcome some of the deficiencies without going to the legislative halls, an Association of Medical Examiners was formed in 1894 with the intent of standardizing the content of the examination and procedural matters. Still the goal was a single examining board for all practitioners of the healing art. By 1900 the AMA Code of Ethics allowed members to serve on examining boards with irregular practitioners.[3] After much effort by the FMA legislative committees, in 1905 the legislature provided a single medical examining board for regular physicians; the Homeopaths and Eclectics had their own examining boards. In 1913 the FMA passed a resolution to seek a composite examining board of: four regulars, one homeopath, one eclectic and one osteopath. This was successfully opposed by the "irregulars" until in 1917 when a scandal broke about the Eclectic Board and its members were removed from office by the governor. Finally, in 1921 a composite board (nine regulars and one irregular) was achieved and empowered to examine all graduates of specified approved schools. Later, 1941, this act was amended such that the board consisted of regular physicians only. By this time the last eclectic school had closed (1939) and the homeopathic schools were teaching primarily allopathic medicine.

This account of the Medical Examining Board of Florida would be incomplete if we did not mention the untiring efforts of William M. Rowlett, a Tampa physician and FMA President in 1933, who for 27 years served as the unpaid secretary of the board. Among many innovative approaches to his task he toured Europe, Cuba and South America at his own expense in 1935 visiting many medical schools to evaluate their curricula. Finding many of them diploma mills he instituted in Florida (perhaps first in the nation) procedures to protect the citizens from ill-trained foreign physicians. This long preceded the examination for foreign medical graduates (E.C.F.M.G.) of today. The Basic Science Examination, no longer in use, was first discussed as early as 1927. It was hoped by this to make certain that anyone of whatever school or discipline who wished to practice the healing art in Florida had enough background in science to successfully perform. The necessary legislation was enacted in 1939 and the

examination was given annually until it was abolished by the legislature in 1969.

State Hospitals

Concern for adequate facilities for the insane and those with tuberculosis has long been an area of legislative activity for the FMA. Thus in 1891 J. Y. Porter called the attention of the annual session to the lack of medical care for the residents of the Florida Hospital for the Insane at Chattahoochee. The minutes of that meeting note, ". . . he knew from observation that epileptics, idiots and weak minded people were all mixed together . . ." An FMA committee was appointed, visited the hospital, and interviewed the superintendent who assured them that very little medical care was necessary for the inmates. This preceded the concept that psychiatric help was needed for the inmates of such state institutions. Repeatedly during the years the FMA legislative committee has memorialized the legislature on the matter of more adequate physical and medical facilities at Chattahoochee, and about the importance of another facility for mental disease "in the peninsular part of the state."

As far back as 1900 the FMA attempted to obtain laws that might inhibit the spread of tuberculosis. However, the material presented to the legislature at that time mentioned that kissing might spread tuberculosis and this provoked the mirth of the legislators resulting in defeat of the proposed bill. In 1903 when the SBH announced its plan to build a chain of "cottage hospitals" throughout the state for the isolation of people with infectious diseases and tuberculosis, the FMA gave its wholehearted support. The legislature of 1927 created a State Tuberculosis Board with the authority to study the situation, select sites, and build hospitals. However, nothing was done and we find the FMA prodding the legislature over the next ten years with the result that the first tuberculosis sanitorium finally opened on January 3, 1938, at Orlando. When legislation was underway for the establishment of a hospital for alcoholism at Avon Park, the FMA again gave its support.

As early as 1929 the FMA launched a campaign to have physicians appointed as coroners in the hope of providing the courts with more adequate medicolegal evidence. Again in 1942 the legislative committee conducted a study of the coroner and medical examiner system and made recommendations.

An early mention of workmen's compensation appears in the minutes of the 1922 meeting when it was presented by Ralph N. Greene, FMA President of 1917. The FMA gave its support to the principle of workmen's compensation but the legislature repeatedly rejected it, possibly because of the stringent times. Finally, in 1935 a Workmen's Compensation Act was passed and, while not always entirely happy with the way it has been managed, the FMA has generally supported this action.

State Medicine

Prior to the turn of the century "State Medicine" appeared in the form of public health measures. However, it was readily recognized by FMA members that the measures involved were clearly not ones that could be accomplished by independent private practitioners. Thus the FMA worked diligently for and enthusiastically supported the establishment of a SBH. There matters lay until World War I when there was talk of a compulsory health insurance that aroused anxiety. However, this died down and lay dormant until the great economic depression in the early 1930's. These were the days of long lines of men registering for relief, Hoovervilles, the "A's" (AAA, NYA, NRA, FERA, WPA, etc.) and of the CCC. The per capita annual income in Florida dropped to $289 in 1933.[8] People who had always been wage earners and able to meet their financial obligations became unable to pay hospital bills and physician's fees. An increasing clamor for assumption of medical care costs by the federal government arose and the press repeatedly drummed the theme of the high cost of medical care. Herbert Hoover appointed a commission to investigate the cost of medical care and the members returned a report indicating that it was beyond the capacity of the average man to meet.

Gerry R. Holden in his President's Address delivered to the 1933 session deplored the current concept, "that citizenship in itself gives the indigent the right to expect not only medical service but every other sort of service and that society at large, the state, is obliged to give it," but he goes on to note very realistically that "the socialistic tendencies which inspired this viewpoint . . . are here to stay." Eleven years later we find President Franklin Delano Roosevelt enunciating his "Economic Bill of Rights" one of the items of which was: "The right to adequate medical care and the opportunity to achieve and enjoy good health."[11]

The FMA tried to fight these threats of socialized medicine ("State Medicine") by a vigorous public education program but met with little cooperation in the press and radio. The society also renewed its efforts to see that all, regardless of financial means, received adequate medical care. Doctors of the state in the care of recipients of relief cooperated with the Federal Emergency Relief Administration and abided by the fee schedule published by that agency:

Office calls	$ 1.00
House calls	$ 2.00 + six cents per mile
Home deliveries	$15.00

Gradually the depression began to subside; perhaps partially due to the relief measures and very probably partially due to the incipient war economy. However, the scent of game was in the political nostrils and the clamor for some form of socialized medicine continued. Florida's Senator, Claude Pepper, an avid supporter of the New Deal, on a national radio broadcast, February 7, 1945, said, "We are not going to settle for half way measures or patch-work proposals. If the voluntary systems offered are to meet our approval they must meet certain conditions. First, the medical care given must be complete care. By that I mean hospitalization, general medical care, including all modern diagnostic and preventive service and dental care. Secondly, the cost of this service to the individual must be low enough so that most of the people can be included in the system. . . . Thirdly, the service rendered must be of high quality . . . we do not intend to regiment doctors or interfere with the right of any patient to choose his physician." Pepper and the Wagner-Murray-Dingell trio introduced legislation for womb-to-tomb care along the lines of the socialistic systems of England, Germany and other countries.

In an effort to meet the problem of medical care costs, in 1942 an FMA study committee was appointed to investigate the possible establishment of a voluntary medical insurance plan. After a thorough investigation of the matter at the 1944 session this committee submitted two resolutions: that the FMA cooperate with the Florida Hospital Association and devise a good hospitalization insurance plan designed to help the lower economic levels; and that the FMA sponsor a nonprofit voluntary medical insurance plan which would pay the physicians' fee for this same strata of society. This was the beginning of Florida Blue Cross and Florida Blue Shield. These plans became functional in September, 1946, and many FMA members in addition to agreeing to join the plans and often accept less than their usual fees, loaned money to the Blue Shield Plan to get it started.

Medical Education

The first mention of medical instruction in Florida is a newspaper notice discovered by Dr. E. Ashby Hammond. In *The Floridian* (Tallahassee) of July 22, 1848, is a notice published by J. T. J. Wilson, M.D. and C. C. Van Wyck, M.D. of Tallahassee proposing to instruct medical students including teaching them how to "compound and dispense medicines and . . . in the minor every day duties of the Surgeon—Bleeding, Cupping, Bandaging, etc., etc." Nothing is known about the success of this early enterprise.

The next formal effort at medical teaching in the state was the founding of the Tallahassee College of Medicine and Surgery in 1883 which is reported in detail elsewhere in this issue.[12] It is of interest that the FMA at its annual meeting of 1885 refused to give its approval to this medical school. Perhaps relevant is the fact that of all the known faculty of this school, both in Tallahassee and in Jacksonville, only one was a member of the FMA, R. B. Burroughs.

As we have seen in the initial Constitution one of the objects of the Association was to "maintain a high standard of professional acquirement" and in later revisions reference is made to the extension of medical knowledge, the advancement of medical science, and the elevation of the standard of medical education in the state. The initial efforts to this end were the encouragement of scientific papers at the annual meetings and the publication of the Proceedings/Transactions/Journal. There the matter remained until 1933 when the president appointed a committee on postgraduate education with Turner Z. Cason as chairman. The purpose of this committee was to establish, under the joint auspices of the FMA and the Extension Division of the University of Florida, a one week postgraduate course to be given annually for the benefit of men in general practice. The first such course was held in late June, 1933, and thereafter annually under the energetic leadership of Cason. At first the course was given in Gainesville, then Orlando and Daytona were tried, and finally Jacksonville was selected as the permanent site beginning in 1940 because of its accessibility and the availability of

air-conditioned hotels. Black physicians were welcomed under the aegis of the Florida Agricultural and Mechanical College of Tallahassee. The attendance varied from 70 to 160 and despite a very nominal tuition, from time to time, the FMA had to subsidize the course."

In February, 1943, at the suggestion of the FMA the State Board of Control for Higher Education established a Department of Medicine in the Graduate School of the University of Florida, Gainesville, with Cason as Director. At this time the postgraduate committee hoped to eventually erect a building in Jacksonville with an auditorium, library and suitable classrooms to house this department. This department presented its first course on June 12, 1946, and then annually thereafter until it became a part of the University of Florida College of Medicine in 1958. Barrow in his history of the University of Florida College of Medicine credits the location of this college in Gainesville rather than Jacksonville partially to the combined efforts of T. Z. Cason and William C. Thomas, Sr., President of the FMA in 1947.[13]

The need for a school of medicine within the state was under discussion at the Association meetings in the early 1940's. A bill to construct a university in South Florida to include a school of medicine and dentistry was passed in the legislature of 1943 but was not funded. Again in 1945 and 1947, the latter with accompanying support from the FMA, legislative attempts were made to no avail. Finally, the 1951 legislature voted to subsidize to the extent of $3,000 per student the first medical school to open its doors within the state. The University of Miami set to work and organized a medical school beginning with 22 students on September 22, 1952. Subsequently the University of Florida College of Medicine began with 48 students on September 4, 1956, and the University of South Florida College of Medicine at Tampa admitted its first 24 students September 13, 1971. Throughout the years the FMA has supported these medical schools both in the legislature and with an annual donation of money.

In addition to the previously mentioned efforts of the FMA to further the education of its members, mention should be made of several other programs. In response to an unusually high maternal mortality rate in Florida during the 1930's, the highest in the nation, the FMA Committee on Maternal Mortality with financial assistance from the SBH and the U.S. Department of Labor conducted seven two-day postgraduate courses on maternal and child health at strategic points throughout the state. These were taught by nationally known medical educators and were well attended. It seems likely that this effort together with other factors helped to reduce the maternal mortality until we are now at the national average. Still another way in which the FMA has furthered the education of its members is in the encouragement of area societies and district meetings. Thus in the past such area societies as: The Midland Medical Society (1916), the Central Florida Medical Society (1921), the Florida East Coast Medical Association (1927) and the Gold Coast Clinical Society (1936) have given a forum for scientific discussions. From 1937 until 1958, each fall except for the war years (1941-1945) district meetings were held. Attended by the members of the several county medical societies of each of the six districts, these meetings provided an opportunity for the exchange of ideas on scientific, economic and organizational matters and served to keep the FMA officers informed on grass roots opinions.

Wartimes

On February 15, 1898, the battleship Maine blew up in Havana harbor and the War for Cuban Independence (April 25, 1898 to August 12, 1898) was soon underway. Thousands of troops with medical officers inexperienced in camp sanitation were rapidly moved into ill-prepared camps at Jacksonville, Tampa, Lakeland, Miami and Fernandina. Disease ravaged the camps producing more than 12 times the number of deaths that resulted from combat. Typhoid fever, the most common disease, accounted for 87% of the 4,784 nonbattle deaths.[8] There was a strong tendency to blame this on the Florida climate, thus besmirching the state's reputation as a health resort. Of course, the real cause was the miserable camp sanitation—the men frequently "took to the woods" to respond to nature's calls rather than use the camp latrines. This period and its problems, perhaps because it was so brief, receives no mention in the Proceedings of the FMA.

Not so with the First World War. The war was declared on April 6, 1917, and one of the actions of the 44th annual FMA meeting convened six weeks later was to telegraph President Woodrow Wilson stating that the members of the FMA in assembly, "do heartily approve of your declaration of war for the cause of justice, liberty and humanity. . . ." The JFMA carried editorials about the war, commending physicians who had

enlisted, and a cumulative monthly Honor Roll of members on active duty. The Bradford County and the Volusia County Medical Societies adopted resolutions that the physicians remaining in practice would remit to the families of physicians on active duty "one third of all gross collections" obtained from the care of that physician's patients provided that he carried a rank below that of major. (A first lieutenant's pay was $2,000 annually; a captain's $2,400; and a major's $3,300.)

Florida physicians responded well to the call to arms, indeed, proportionately Florida was highest in the South and 11th in the nation in the number of physicians who saw active duty. In all 228 of the 1,321 practicing physicians of Florida were at some time on active duty during this conflict.[8] By May, 1919, 45% of the FMA members had been on active duty. Since the dues of the members on active duty were waived, there was a sharp decline in the society's income. To offset this and continue publication of the JFMA, a "War Tax" of $1.50 annually was levied upon the remaining physicians and apparently was paid cheerfully.

On the home front medical activities were not nearly so feverish as during the War for Cuban Independence. The military activities within the state consisted of five air fields (one at Pensacola, two at Miami, and two at Arcadia) and an Auxiliary Remount Depot (Camp Joseph E. Johnston) at Jacksonville. There were also naval activities at Key West, Tampa and Pensacola, and a small naval air unit at Coconut Grove, which brought protests from the guests at the Royal Palm Hotel located at the mouth of the Miami River. The only disease of note during this period was the pandemic influenza of 1918 and 1919 which resulted in over 30,000 cases with 464 deaths in Jacksonville.[8]

The Second World War made Florida into "a giant military training school and army and navy airfield."[8] Many thousands of military personnel received training here; major resort hotels throughout the state were turned into military barracks. Over 258,299 Florida men and women saw active duty between December 7, 1941, and September 2, 1945, as compared to 42,030 in the First World War. One thousand eight Florida physicians, of which 486 were FMA members, were at some time on active duty. Indeed, Florida physicians volunteered with such enthusiasm that the physician recruiting offices were closed early in the war.

Again, a dues exemption was provided for physicians on active duty beginning January 1, 1942. As previously, this resulted in a sharp drop in the Association's revenue and the balance on hand reached an all-time low of $18.84 in April, 1944. In an effort to avoid this, during 1943 members remaining in practice were solicited and $3,541.63 was donated to be invested in War Bonds and kept as a reserve fund. Partly because of this fund the FMA remained solvent.

To supply physicians in areas where there was a critical need Governor Spessard Holland with FMA approval gave an Executive Order to the State Board of Medical Examiners to issue temporary licenses to practice. These licenses were valid for the duration of hostilities and could be issued without examination to physicians who held a valid license from some other state and who would agree to practice in the area where the shortage existed until the war ended. Such physicians could become members of the county society and the FMA just as the regularly licensed physicians. Many of these physicians subsequently took the state board examination and are practicing in the state today. This method provided 62 temporary licenses during the course of its existence, January 8, 1944, to July 1, 1946.

Because of the stress on transportation facilities and the great demand on the remaining physicians' services, the district medical meetings were abandoned from December, 1941, until October, 1945. Also as we have seen, the annual meeting of 1945 had to be cancelled at the last minute. As there were no provisions in the By-Laws for the election of FMA officers other than at the annual meeting, the Board of Governors ruled that the incumbent officers would serve until the annual meeting of 1946. Thus President John R. Boling served a second term without being reelected.

Victory was achieved in Europe on May 7, 1945, and in the Pacific on September 2, 1945. By early 1945 monthly reports of physicians returning from the war theaters and resuming their practice began to appear in the Journal. Many a county medical society meeting was enlivened by accounts and yarns of experience in the service. One of the more dramatic and a true account appears in the June, 1945, issue of JFMA. This is an editorial by Homer L. Pearson about the return of Colonel Frank S. Adamo of Tampa. Colonel Adamo, a medical officer with MacArthur's dwindling forces, participated in the

retreat to and defense of the cavernous rock fortress, Corregidor. He achieved national fame for instituting wide open surgical incision as a treatment for gas gangrene. Captured by the Japanese when Corregidor fell, he spent two and one-half years at Manila's infamous Bilibid Prison. Emaciated and almost blind from a daily diet of 50 grams of rice, 100 grams of corn and 50 grams of soybean, occasionally varied by a few wispy greens (dubbed by the soldiers "whistle weed") or dried salty fish, he was barely able to walk when freed by the American forces.

Conclusion

Thus ends this account of the activities and accomplishments of the FMA during its first three-quarters of a century. Of course, these accomplishments are the accomplishments not of the FMA but of the many dedicated physicians whose persevering efforts brought them about. Although but few could be named in this account, this Association has been especially fortunate in having as it does today, a large number of intelligent, farsighted and dedicated physicians at its helm. The results of the collective labors of these men, often at significant personal expense and almost always at personal inconvenience, have benefitted the citizens of Florida as well as the physicians, both those active in and those not active in the FMA.

This is a day when it is popular to carp at "the establishment" for its actual or imagined shortcomings. From the individual's standpoint organizations do have their faults, yet despite these faults no reasonable man will assert that the good accomplished by the FMA over the past century could have been achieved without the concerted action of organized physicians. The future bodes an even greater need for collective action as we are more and more pressured by the population density and the complexity of society.

Rightful goals for a man's life are a contribution to the welfare of his fellowman and some degree of freedom in shaping his own destiny. Time was when these goals might reasonably be attained by independent effort but this time seems gone forever. Significant accomplishments are hardly possible now-a-days without a team effort. And to use the oft-quoted remark of Thomas Paine: "Those who expect to reap the blessings of freedom, must, like men, undergo the fatigue of supporting it."

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*Unless specifically cited to another reference the material in this paper is found in the Proceedings/Transactions/Journal of the Florida Medical Association.

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Florida Medical Association Its Past Twenty-Five Years

Richard Marion Fleming, M. D.

As the Florida Medical Association entered the last quarter of its first century, the post-World War II world was shaping up and the seeds for future conflicts and problems had been sown; indeed, some of these had already begun to sprout. As citizens we were concerned with these international problems, but as physicians our attention and concern were directed toward domestic developments which would affect us both as a profession and as individuals.

Health legislation strongly supported by the Truman administration had been introduced via the Wagner-Murray-Dingell bill and Senator Claude Pepper. The effects of this legislation in the view of most FMA members would be the beginning of complete socialization of medicine as had just occurred in England under the Labor Government.

It is small wonder, then, that physicians were jolted from their traditional position of nonparticipation in policies to one of active concern with the legislative process.

Walter Payne in his presidential address of 1950 said: "In congressional races this year the overshadowing issue is whether the American people are ready to abandon their independence for state socialism." Joe (Joseph S.) Stewart, Chairman of the Public Relations Committee, reported that through the FMA educational campaign "thousands of persons have been taught what the aims of medicine are and what the dangers of Compulsory Health Insurance mean." By the time of the 1951 meeting, President Herbert White announced "Within two short years, American medicine has dealt a mortal blow to the nefarious schemes of the Ewing (Oscar) clique." This was in reference to the first stirrings to political action by physicians which in Florida had contributed to the unseating of Claude Pepper in the U.S. Senate.

It seemed, however, that we were to get very little reprieve by the victory and the blows were not so mortal as predicted. The problem of intrusion of government into medical matters, particularly after 1966, was to command the increasing attention and concern of FMA members and occupy the time and energies of the headquarters office. There was a brief period, however, when the urgency of the problems seemed, to some at least, to have abated. This prompted one county medical society to recommend in 1955 that the public relations program be abolished since socialized medicine had been defeated and we could now reduce our FMA dues. (Beautiful dreamers!)

Legislative Activities

To help make FMA views known to legislators, an office was opened in Tallahassee in 1947. Later, during the April and May legislative session, Harold Parham, director of public relations, was in charge and Ben C. Willis of Tallahassee was retained as legal counsel on legislative matters. From a small beginning the office grew to a year round operation and by 1969 a full-time director and staff were employed. In 1973 no fewer than 233 legislative proposals required action by the FMA legislative committee or staff. Our position was more often sustained than not.

Key contact physicians were appointed for each state legislator in 1947 and for each congressional legislator in 1952 to insure that he or she could be personally contacted when important legislation affecting medicine was to be considered. In 1954 the key contact physicians as a group made the first of their annual visits to Washington to discuss medical legislation and related matters with Florida senators and congressmen. This annual meeting has proven to be highly effective in maintaining an ongoing rapport with the congressional delegation.

Growth of Florida Medical Association

In the last quarter century the Florida Medical Association grew not only in numbers but in other parameters. From 2,823 licensed physicians in Florida in 1949, the number had increased to

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18,340 in 1973 of which 10,790 were residents of Florida. FMA membership rose from 2,050 to over 9,000. This growth rate exceeds even the explosive total population growth of the state during the 1960's when Florida's population increased by one third and rose from 20th to ninth among the states.

In 1950 FMA headquarters employed nine persons — three in an executive capacity and six clerical. By 1973 ten executive and 23 clerical personnel were required to manage the Association's affairs. In 1949 the Association had a total income of $66,557, expenses of $56,783 and assets of $90,791. By 1973 this had risen to an approximate income of $725,000, expenses of $710,000 and assets of $850,000.

Whereas the recording of proceedings of the 76th Annual Meeting in 1950 required 35 pages in the Journal, by the time of the 98th meeting 76 pages were required and even with this amount of space the detailed financial report, published in previous years, had to be omitted. From 19 committees in 1949, the interests and activities in over 200 programs by 1970 required over 100 committees serving under eight councils which then reported to the Association at the annual meeting through five reference committees. The number of members actively involved in this work runs into the hundreds and the man hours of work volunteered runs into many thousands.

Headquarters—Management and Building

As active and dedicated as so many FMA members have been, serving as officers or committee members, it was obviously impossible to carry on these functions and services without a full-time professional staff. Heading this staff which he recruited and built up over a period of 27 years to become a highly organized and smoothly functioning team was Stewart Thompson, D.P.H. At the 78th Annual Meeting on April 30, 1952, Dr. Thompson was presented with the Certificate of Honor for 25 years service to the FMA. When his death was announced at the opening session of the 79th Annual Meeting on April 27, 1953 (his funeral was held that same day) a pall fell over the assembled delegates not only out of a sense of sorrow at our loss, but also because of a feeling that Stewart was irreplaceable, so heavily had FMA leaned on him through the years. For the next five years, Ernest Gibson, who had been Assistant Managing Director, served the Association well as Acting Managing Director. In 1958 the position of Executive Director was created and Harold Parham was named to that position. Harold had already shown his enthusiasm, energy and initiative as director of public relations and we soon knew that we had another highly competent executive at the helm.

So outstanding has been Harold's performance that in the last 12 years, each president in his presidential address has paid him tribute, not always as flowery as Leo Wachtel's description in 1961—"A jewel in a setting of his own creation—a thing of beauty"—nevertheless, all acknowledged their gratitude to him for his service beyond duty. Jim (James T.) Cook once confessed at a meeting of the Board of Governors just after he had become president that he had had a nightmare in which Harold Parham had vanished, leaving Jim to carry on. Jim says he awakened in a cold sweat, first at the terror of having to "run the show" without Harold and only secondly (and later) with a feeling of sorrow at the loss of a friend!

Mr. Parham

In 1964 the Board of Governors presented Harold Parham with a citation for "his many contributions to medicine and the doctors of Florida." His title was changed to Executive Vice-President in 1969.

Of the many other wonderful, devoted people at our headquarters office, a word of appreciation should be officially recorded though space does not permit mentioning them by name.

As the FMA grew in numbers, programs, responsibilities and interests, so did the need for expanding the physical facilities and staff. At the annual meeting in 1956, John Milton announced that after several years of looking and planning by the Building Committee, under the leadership of Edward Jelks, a site for the new FMA home had been purchased, plans drawn and construction was proceeding. Two large lots on Riverside Avenue fronting on the St. Johns River were acquired; the building was erected on one while the other was paved and leased as a parking area. The total cost of the lot and building was $156,762. On September 15, 1956, the building was properly dedicated and it appeared that the Association had planned ahead adequately for the next third of the century with room to expand when desirable. Unfortunately unforeseen events have a way of disturbing one's best laid plans. It seems that the city of Jacksonville had other plans for the waterfront property of the adjoining lot. Condemnation proceedings by the city have forced the FMA to relinquish a portion of its lot on the river (about 25%)—for a sewage pumping station of all things! Although this new "addition" certainly contributes nothing to enhancement of the property, it does not interfere with operation of headquarters offices; as a matter of fact, plans are currently being drawn for an addition to the present building.

State Board of Medical Examiners

The members of the Florida State Board of Medical Examiners are appointed by the governor (usually from a list of nominees submitted by FMA) and this Board has the power to issue or revoke licenses to practice medicine in Florida. Homer Pearson, former FMA President, served as Secretary-Treasurer of the Board from 1950 to 1960 and it was largely due to his leadership and prodding of the legislature that the Medical Practice Act was revised in 1960 (effective 1961) giving the Board greater responsibility in policing physicians. Dr. Pearson was named Executive Director in 1960, a position he held at the time of his death on May 10, 1967. The registration fee was raised from $1 to $10 to provide funds for investigations, hearings, etc. This money was collected (about $350,000 by 1970) but held "in

Headquarters of Florida Medical Association, Inc.

trust" by the state, prompting a resolution from the FMA Board of Governors in 1970 to release the money so the Board of Medical Examiners could function properly. The Basic Science Law was repealed in the Act's revision although this was vigorously opposed by the FMA. Subsequently overtures to the legislature to rescind this action have fallen on deaf ears.

In 1963 out of 409 applicants for licensure, 380 were licensed. By 1971, of the 2,349 physicians examined, 1,761 were licensed and Dr. Pearson's prediction of 1956 was fast becoming fulfilled — "at this rate of increase in Florida there'll soon be a shortage of physicians in the *rest* of the country!"

In 1971, stimulated by pressure to relax the licensing procedures for physicians coming to Florida, the FMA approved licensure by limited reciprocity or certification of those physicians who pass Part Three of the National Boards or FLEX within eight years preceding application. The physician must establish practice within three years of obtaining his license. This led within the first year to the licensing of 134 physicians by endorsement in addition to a record 1,961 out of 2,728 applicants who were examined. The work load of the Board of Medical Examiners increased so much that in addition to a full-time M.D. director there were by this time ten M.D.'s on the Board who spent a minimum of 21 days out of their own offices annually, meeting six times a year with the prospect of increasing the frequency to eight times a year. Between 1970 and 1971, investigations increased from 29 to 171, hearings from 38 to 61.

Veterans Administration and Military Dependents

In the post-World War II years, FMA developed a relation with Veterans Administration programs and later as a result of the Korean War and other military commitments became involved in caring for military dependents.

The veterans programs were subject to some criticism, according to reports of the Subcommittee on Veteran Care beginning in 1950. Although the fee schedule was revised completely in 1953, and apparently to an acceptable level, by 1955 disenchantment had set in leading the chairman to report that the "most important activities (of the Subcommittee) during the past year — to work on informing doctors concerning the evils of the Veterans Administration Program of non-service connected disabilities." This theme recurred each year and in 1957 FMA was urged "to get the V.A. to stop treating non-service connected disabilities — economy in government is necessary to provide money for national defense." An ingenious argument to say the least! At any rate, opposition to the V.A. practices gradually gave way to more important priorities in federal government intrusion into medical care but not before a hassle arose between an FMA member and the V. A. The physician prescribed Metrecal for a V. A. patient. Not a prescribable foodstuff, said the V.A. moguls—ergo the physician must reimburse the veteran the $98 which he had spent for the stuff. It took practically the entire legal staff at FMA headquarters to argue with the V. A. people and finally establish with them the fact that it is not the doctor's obligation to be responsible for payment for prescribed drugs or foodstuffs!

In reference to the care of dependents of military personnel, the FMA in 1953 approved in principle the position adopted by the AMA which stated: "If in the independent judgment of the Department of Defense or Congress, the welfare of our preparedness program requires that dependents (of service men) receive medical care on a service basis . . . the medical profession stands ready to provide such service through Blue Shield or other county medical society plans." This rather cautious approach gave way later to direct negotiations by the Defense Department with various state medical societies to provide these services through its members on a fixed fee schedule. This was met with some skepticism and even open opposition leading to much discussion at the 1957 Annual Meeting. The result was a resolution not to renew the fixed fee contract but to make a new contract on a usual fee basis. This program was called "Medicare" and it evoked a great amount of anxiety at the spectre of federal "take-over" of medical care . . . as a matter of fact, "Hog" (William R.) Roberts, in his president's report on actions of the Board of Governors in 1958, stated that "Medicare has been the major item at the board meetings this past year." It was not until 1966 that FMA learned what the "real thing" was and changed the name of the committee to the "Military Dependents Committee." In 1960 the federal government contracted with Blue Shield to provide health insurance to the military dependents and the FMA furnished a mediation committee to review claims. This apparently proved to be a satisfactory arrangement, for the FMA was commended by a

representative of the Defense Department as having one of the most active and cooperative groups in the country and he stated that complaints concerning care of military dependents in Florida were practically nonexistent.

Medicare

Having had this preliminary "warm-up" prior to the main event which was to come July 1, 1966, much input into the writing of the Medicare bill came from the medical profession, some of whom were FMA members. As Phil (H. Phillip) Hampton stated in his presidential address of 1966 . . . "in its enactment (Medicare) we lost a battle to prevent Federal assumption of obligation to provide personal services as a right of citizenship . . . we have gained an advantage in the war to preserve individual freedom in the practice of medicine." Two fundamental principles were won with the separation of Part A (hospital services) from Part B (physician services), and the provision for a medical insurance carrier.

Two other significant achievements in these early years were of great value to FMA members in helping to exert some influence or at least to have a source of input in the relations of the medical profession with the federal government. These were the acceptance by the government of the two FMA recommendations: the naming of Blue Shield as carrier for Part B insurance and the entire State of Florida as an administrative unit.

Many Association members did not grasp the significance of these accomplishments, having failed to follow developments in Congress and to appreciate the inexorable progression of federal financing of medical care for a considerable segment of our citizenry, with the inevitable controlling regulations and audits which this would require. Fortunately, the FMA's leadership did appreciate the nature of the problem with its long-range implications and acted promptly and vigorously to meet them. In 1969 FMA named the Florida Medical Foundation as the body to negotiate with Blue Shield for a contract to do peer review and adjudicate Medicare claims. By 1970 a state Peer Medical Utilization Review Committee under chairmanship of James Byrne, had been organized and county medical society committees were ready to perform this function at a local level. By then Medicare had been in existence for about four years. During that time, while regulations and rules were being formulated at the federal level and the computers were being programmed to provide massive data to evaluate profiles of services and charges, there had been a very loose and capricious type of administration of the program and aside from the increased paper work, physicians were not having too much trouble with Medicare. Suddenly with the machinery geared to monitor services and charges and develop norms for various procedures, the computer began to spew out hundreds of claims that deviated from the norm. These were all checked carefully by a reviewing M.D. in the Blue Shield office and those claims presenting a valid reason for review referred to the local committees. The number of claims referred reached a flood stage shortly because of the backlog of cases extending back to 1967 and this put an enormous strain on some of the local committees to say nothing of the strain on the physician who was being investigated! Several other factors aggravated an already difficult situation. HEW often took unilateral action in an arbitrary if not arrogant interpretation and administration of Title XIX; demanding reimbursement for payments already made; using an across-the-board reduction in payments based on a sampling of a physician's cases; withholding of all payments to physicians under review; releasing highly prejudicial information injurious to physicians; refusal to provide information to individual physicians, etc. There followed a rising tide of resentment, anger and frustration in the medical profession especially among those subjected to review. These feelings while aimed at the Medicare program, found their immediate target in the fiscal agent of the program, Blue Shield, and in the medical representatives to Blue Shield and Peer Utilization Review members. This resentment even went so far in some members as to call for withdrawal of Blue Shield as the Medicare fiscal agent and in one county at least to the abolishment of the PUR committee! The latter action resulted in FMA's assuming the position that if the component county medical society did not perform its own peer review, it would be done at the state level, thus removing the physician in that area a step further from true local PUR.

Many of the membership failed to realize that Blue Shield had nothing to do with setting policies in Medicare but simply acted as an administrator of those policies. They also failed to realize that only through an organization such as Blue Shield where our physician representatives exert some influence on its policies was

there any chance of altering Medicare activities and procedures. When the contract with HEW was signed by Blue Shield in 1967, it was with the understanding that "if the contract is inimical to the policies of Blue Shield or to the relation of Blue Shield to FMA or to patient-physician relationship, it will be cancelled in ninety days." Blue Shield did succeed in 1972 in getting HEW to change its policy in withholding funds from physicians under review so that if the amount in question was less than $4000 none was withheld. It was finally able to get the Bureau of Health Insurance to allow the statement on explanation of Medicare benefits: "This payment does not necessarily cover the physician's entire fee." Blue Shield fought against disclosing the names of doctors subjected to peer review and for making available to nonassignment physicians a copy of the explanation of medical benefits in Medicare which is sent to their patients.

Florida Medical Foundation

During the early 1950's the idea of developing a foundation similar to those of corporations began to emerge and, with proper legal guidance, the Florida Medical Foundation was established in 1956 as a nonprofit organization. The FMA's Board of Governors constituted the Foundation's Board of Directors and Dr. Edward Jelks, who had been one of the leading proponents of the plan, was named as its first president. The purposes of the Foundation as listed in the charter are: To improve the health and medical care of the people of Florida, sponsor graduate and postgraduate educational programs, assist needy persons pursuing a medical education, aid needy physicians and sponsor medical research. This rather broad charter has enabled the Foundation to receive gifts, grants and bequests to be used for these purposes, to set up and administer trust funds for a number of organizations of FMA members, to serve as fiscal agent and/or administrator for certain government financed programs and to contract for certain services with federal and other agencies. Most notable among the latter is the agreement with Blue Shield to provide Peer Review for both Blue Shield and Medicare.

With the expansion of federal and state financed programs of medical services it seems likely that the Foundation will play an even greater role in the future in negotiating with governmental agencies in behalf of FMA members and serving as administrative or fiscal agent in some of the programs.

Foundations for Medical Care vs Health Maintenance Organizations

Recognizing the need for exploring alternate methods for the provision of medical care for some segments of our society, the FMA adopted certain criteria for the organization of Foundations for Medical Care by FMA members. Essentially these Foundations would be organized as units, consisting of the physicians of one or more counties, to provide medical care by a prearranged system of payment while preserving the fee for service principle. As of 1972 the Board of Governors had approved the charters of Medical Foundations in three counties: Duval, Escambia and Dade (later Dade-Monroe) and although none of these programs had actually begun to provide medical care, negotiations were in progress in at least one of the counties. Health Maintenance Organizations, on the other hand, propose to furnish complete health care on a prepaid basis in which the physician may be paid in a variety of ways, including salary or capitation. They may be organized by various groups or individuals including laymen who may operate the HMO for profit. Because of the great appeal of this plan to many persons both in and out of government, there has been official congressional support with the promise of even more federal funds in the near future. In 1972 an Ad Hoc Committee under chairmanship of James Borland Jr. drew up a statement presenting FMA's position concerning HMOs. In essence FMA approved the pluralistic approach in providing health care and indicated a willingness to explore new methods of health care coverage provided the care is not downgraded and the patient is not exploited.

Professional Service Review Organizations

After the Bennett Amendment to the Social Security Bill was passed in 1972 there was much confusion as to how this law would be implemented and discussion by a few, at least, as to whether or not it should be repealed. Although the law did not require the Secretary of HEW to even designate the geographic units for operation before January 1, 1974 and gave the physicians until January 1, 1976 to organize local PSROs, the FMA took the initiative in dealing with this problem. In 1973 the House of Delegates authorized the establishment of a "Florida Professional Standards Review Organization" to serve as prime contractor for the state providing

computer and support services to and for not less than 12 local PSROs. Although the senate report on the Bennett Amendment referred to no more than 3,000 physicians to a single PSRO, this regulation is being challenged, and if it is changed FMA can take some of the credit because of its early and persistent efforts. Regardless of its final form, certainly some control such as PSRO seems inevitable and it would seem highly desirable to keep the "P" (Professional-Peer) in any standards review organization.

Professional Liability Insurance

The FMA first considered group liability insurance in 1921 but it is not clear that any action was taken. Some time in the 1930's a group policy with the Aetna Casualty and Assurety Company was negotiated. In June, 1941 a JFMA editorial notes that the losses had been more than expected and the premium for basic coverage would be raised to $25 annually.

In the subsequent years it became even more difficult to get satisfactory liability coverage and the premiums kept climbing in response to alleged losses. In 1955 Robert Zellner with his Committee on Medical Economics did an exhaustive study of this problem. They contacted all of the 48 state societies to obtain their experience. Among their several recommendations the Committee suggested the FMA collect its own statistics on losses and that the Board of Governors be empowered to contract with Marsh and McLennan, a national insurance firm, to be the exclusive broker for FMA. However, a year later Dr. Zellner reported that Marsh and McLennan was having difficulty getting an underwriter for FMA; they had at that point been refused by 30 companies. In the meantime over strong protest from the FMA the insurance commissioner of Florida had granted rate increases of 87% for physician's coverage and 111% for surgeon's coverage. Finally, in October 1961, a group professional liability insurance contract with the Employers Insurance Company became effective.

For several years things seemed under control but the frequency of suits and the spiralling amounts of the awards, particularly in the Dade-Broward area, led to steadily increasing premiums much to the resentment of FMA members. Nationwide, there had been a 539% rise in professional liability premiums in the decade 1960-1970. In 1960, nonsurgeons of the U.S. paid $7,600,000 for this protection while in 1970 the figure had risen to $48,700,000. Surgeons were even worse off, their coverage rising from $19,700,000 to $206,700,000 in the same period! Despite these astronomical increases in premiums, in 1972 the insurance carrier notified FMA that it would not renew contracts at the expiration of the contract period. This led to a vigorous exploration of the insurance field for a new carrier and by 1973 negotiations had been completed with the Argonaut Insurance Company to provide coverage for FMA members under terms much more satisfactory than the previous contract provided.

Largely as a result of this experience and because of difficulties encountered with the management and administration of FMA insurance programs, an indepth review of Association sponsored insurance programs was undertaken. In July 1972 a stock for profit corporation was organized and incorporated under the name Flamedco Inc. The corporation is wholly owned by FMA and authorized to conduct appropriate business in behalf of the Association's interest. Harlan Insurance Company of Texas was then approached to form a joint agency for administering FMA insurance programs. Harlan-Med Inc. was created in October 1972 as a jointly owned and operated agency with the FMA owning stock. This enables FMA to totally control the administration of its sponsored insurance plans and also to participate in the stock dividends income of the agency which it created with Harlan.

This is a new and unique approach to the conduct of business by medical associations which will undoubtedly be copied by others in the future. As a matter of fact, Mr. Parham was asked to present this plan to the American Association of Medical Society Executives.

Public Service and Education

Among the many active committees of the FMA, a standout throughout the years has been the Committee on Maternal Health. Through efforts in education of both patients and physicians and collaboration with the State Board of Health, maternal mortality had been reduced from the high levels of the 1900's. One of the approaches to this problem in the 1950's was the institution of an annual Tristate Seminar in Obstetrics and Pediatrics. The first of these, personally subsidized by the committee chairman, Frank McCall, to the extent of $480, was held at Daytona Beach in 1953. It was cosponsored by the Boards of Health of Florida, Georgia, and

South Carolina, and attended by physicians from these states. Throughout the years, this has been one of the best attended seminars in Florida.

Another active committee, the Committee on Venereal Disease Control, which acted as liaison between the SBH and the practicing physician, was able to report a steady decline in both syphilis and gonorrhea between 1950 and 1957. Members were congratulated on their fine cooperation with the SBH in case finding and follow up. But this ideal situation came to a screeching halt with the development of the "Pill" (contraceptive pill) and the loosening of sexual mores. In the year 1959-1960, the Committee reported, new cases of syphilis were up 71% and of gonorrhea 19%. Throughout the 1960's there was a steady increase in these diseases until they reached epidemic proportions in the early 1970's.

A legacy of the Vietnam War was the escalation of the drug abuse problem which began to blossom in the 1960's. Although this problem had occupied the attention of the larger county medical societies for some time in their school health programs, the earliest mention of the problem at an annual FMA meeting was in 1969 when the House was addressed by FMA Woman's Auxiliary President, Mrs. Linus W. Hewit. She detailed the Auxiliary's extensive and effective educational program for teenagers on the problems of drug abuse, alcohol and sex which had been in operation the previous year. The first official FMA effort in this matter was the organization of an ad hoc Committee on Drug Abuse in 1970. This was an interdisciplinary committee including the FMA Woman's Auxiliary, attorneys, pharmacists, law enforcement officers, educators, clergymen, physicians and others. This Committee has attacked the problem vigorously, stimulating efforts aimed at the education of physicians and the public, the organization of local drug abuse committees, providing consultation, advice and review of proposed legislation, investigating the handling of youthful offenders by the courts and the State Division of Youth Services, and in other ways.

Workmen's Compensation

A Workmen's Compensation Act was passed by the state legislature in 1935. A basic misconception concerning reimbursement of physician's services to injured employees has persisted throughout the years, namely, that since the workman's insurance is paid for by the employer, the physician should accept a lower fee than he would charge a patient who was not financed by Workmen's Compensation. In other words, the physician is called upon to subsidize the program. The 1952 Board of Governors was told by the Commissioner of Workmen's Compensation, "the duties of the commissioner in administering the Workmen's Compensation are somewhat socialistic . . . but (this) was demanded at the time of enactment." After much pressure from the FMA, a new fee schedule was adopted in 1953 with modest increase in physician's reimbursement. In the subsequent years attempts have been made to get the Industrial Commission to accept the schedule of fees as set forth in the revised Florida Relative Value Study which was adopted in 1963. However, the committee appointed to negotiate with the Industrial Commission noted they did not expect the commission to accept this without a fight and they were right. After many conferences with the Industrial Commission proved fruitless, the House in 1967 authorized the Board of Governors to seek legal means of obtaining usual and customary fees as is prescribed by the Workmen's Compensation Act and based on the Florida RVS. After more years of maneuvering and skirmishing, a new fee schedule was obtained in 1972 but even this does not comply with the intent of the Workmen's Compensation Law.

Osteopathy and the FMA

Recognition of osteopathy by the Armed Forces and federal government agencies as a branch of the healing art on a par with regular medicine prompted investigation by the AMA as well as several state medical societies into the current status of this practice. Some states, notably California, began to accept osteopaths with privileges equal to those of the M.D. They also offered M.D. degrees to practicing osteopaths upon application. The FMA was not in the vanguard of those organizations which proposed a new relationship with the osteopaths. In 1962 a statement adopted by the House was, "We do not recognize such a thing as osteopathic medicine . . . it is a cult." It was considered unethical for an FMA member to consult professionally with an osteopath. Although the matter came up for discussion repeatedly during the ensuing years, the FMA position remained unchanged until 1969 when two Dade City osteopaths entered a suit charging the FMA with denying them privileges in the hospital of that community and thus violating the Sherman Anti-trust Act. Although the FMA won that suit and the de-

cision was upheld on appeal, legal counsel advised that the decision was on shaky ground legally and might well be lost with devastating financial penalties should FMA be challenged again. With this rather sobering bit of information, coupled with the facts that the AMA had long since dropped its opposition to osteopathy and that some specialty boards were accepting qualified graduates of osteopathic schools for residency training programs, the FMA modified its stance. By 1971 the House adopted resolutions which permitted osteopaths to attend FMA scientific sessions as guests of FMA members, medical schools within the state to accept osteopaths for postgraduate courses, and each county medical society to decide for itself the degree to which their members were to associate professionally with osteopaths. The Judicial Council was instructed to draw up guidelines for the use of the county societies and was required to pass on the acceptability of county society regulations on this matter. By 1972, 11 county societies had received approval of their plans for M.D.-D.O. relations.

Reorganization

Although there have been annual changes in the By-Laws, committees being added or deleted and new functions assumed requiring changes, a complete review of the structure and function of the FMA had not been undertaken since 1959 which resulted in the Speaker of the House system, our Council Structure for Committees and a Council on Specialty Medicine. In 1970 the House referred to the Board of Governors a resolution calling for reorganization of the Association. The Board, in turn, appointed an ad hoc committee under the chairmanship of the old reliable wheel horse, Bob Zellner, to study the structure of the FMA. This committee studied the structure of other state medical societies of comparable size and held a well-publicized hearing for members to speak their piece. Only a handful of people appeared at the hearing or submitted suggestions by mail. This led the chairman to observe, "Either there is widespread satisfaction with the present structure or appalling apathy." After further study, the committee recommended changes in the By-Laws which were adopted at the 1972 session. These limited the size of the House to a maximum of 250 members and gave the privilege of the floor for the past presidents, members of the Council on Specialty Medicine (without the right to vote) and certain others. The Vice-President became a member of the Executive Committee, the delegates to the AMA were ranked according to length of service, and the duties of the Council on Speciality Medicine were more fully delineated.

Continuing Education

Support of medical education has long been one of the main activities of the Florida Medical Association. This has taken the form of support of postgraduate courses of various kinds, upgrading of scientific programs at the annual meetings and supporting each of the medical schools as they have come into being. As more and more national medical societies have taken advantage of our climate and convention facilities, opportunities for postgraduate education "in their own backyard" have become abundant for Florida physicians. Despite these extremely active and effective efforts at updating and upgrading medical education at all levels voluntarily, when the federal government "got its nose under the tent" of medical care, the element of compulsion entered the picture.

While it would be incorrect to say that all FMA members took advantage of opportunities to continue their education or that the result of compulsory continuing education would be anything but good, many FMA members feared that once this principle of compulsory continuing education was accepted, recertification and relicensure would not lag far behind. The first resolution dealing with compulsory continuing education was introduced in the House in 1967 and referred to the Board of Governors for study. In 1972 a Committee on Continuing Medical Education was appointed and charged with presenting to the next annual meeting a proposal for compulsory continuing medical education. Their proposal was adopted after much discussion in 1973 and beginning January 1, 1974, to retain membership in the FMA, each member must accumulate 90 hours of documented continuing medical education each three years.

This new policy beginning as it does on FMA's 100th birthday might be interpreted as an omen, good or bad. The author chooses the former since it embraces the traditional concept that a physician never ceases to be a student, and it reaffirms a cherished tradition of self-regulation.

Epilogue

The Second Hundred Years

As one looks ahead and attempts to foresee the changes which will take place in medicine, it is possible from current activities to speculate on some of the changes which may occur in the near future. Should one try to visualize the practice of medicine in 2074, however, about the only prediction that can be made with assurance is that the changes will be even more remarkable than those of the first 100 years.

The first order of world business in the coming century will be preservation of the planet and the human race. We must assure that the earth is not destroyed by means we already possess, that its life-supporting materials are preserved, that life does not become polluted out of existence and that we do not breed ourselves into degeneration or extinction. To accomplish this will require not only a tremendous international cooperative endeavor with some blurring of national boundaries and racial distinctions but also the relinquishing of some individual rights and privileges which have been inherent since the birth of our country. It appears likely that the knowledge and talents of medicine will be needed for preservation of the race.

We have already experienced some of the depersonalization of the computer in our daily lives and this will undoubtedly continue into the foreseeable future; the challenge is to prevent or counteract its dehumanizing effects. As norms are developed, the individuals who stick out beyond these "usual and customary" ranges become more of a problem in the mechanistic computerized society. It may well be that one of medicine's great contributions will be to serve as a reservoir of personal freedom and individual initiative.

In the case of the individual patient a close interpersonal relationship between him and his physician will continue to be important in the patient's physical and mental recovery. Although much of the work related to the care of the patient is necessarily delegated and there are many areas where first rate care demands a team effort, fortunate is the patient whose personal physician directs the team, collaborates with the team or is able to utilize the expertise of and/or the information generated by the team to his patient's greatest advantage. This commodity cannot be mass produced or neatly packaged into interchangeable units.

Finally, there will continue to be a need for an organization of physicians in Florida to provide a forum for the exchange of ideas among these like-minded men and to enable them to convey to society at large the results of their deliberations in single voice. If the initiative, energy and intelligence displayed by the leaders of the FMA during the past century continues, the Florida Medical Association will be that organization.

▶ Dr. Fleming, 1688 Meridian Avenue, Miami 33139.

FMA Past Presidents

FMA Past Presidents

*Current President, Dr. Joseph C. Von Thron, Page 5.

History of the Journal of the Florida Medical Association

Clyde M. Collins, M.D.

At the first Annual Meeting of the Florida Medical Association in 1874 a secretary took the minutes in longhand but it was not until the second Annual Meeting on February 17, 1875, that a Committee on Publication was instructed to print 250 copies of the two meetings to be mailed to every member as the "Proceedings of the Florida Medical Association." This was sent to Cogswell Printers at Charleston, S. C., as no one in Florida was thought competent to do the job.

Some 11 years later in Jacksonville there appeared a Florida Medical and Surgical Journal whose editor was T. O. Summers, M.D., a student of Virchow, who taught anatomy at Vanderbilt University before moving to Florida. Ten issues later, although editorially supporting organized medicine, it had failed to gain acceptance as the official publication of the Florida Medical Association and was merged with the New Orleans Medical and Surgical Journal.

In 1898 at the 25th Annual Meeting, held at the Board of Trade rooms in Jacksonville, a motion was approved that the Georgia Journal of Medicine and Surgery be designated as the official Journal of the Florida Medical Association, and several issues of that Journal did carry such information on its cover. This apparently incited little interest for in 1899 the report of the Committee on Publication said nothing of a consummation or discontinuation of this proposal. In its report, the Committee uses the word "journal" to describe the Transactions and 500 copies were printed at a cost of $124.50. The Committee expressed regret in the delay of getting this to the members but stated that the fault was the printer's because of work he had previously promised the government during the occupancy of the city by the 7th Army Corps. At this meeting the "Proceedings" had become the "Transactions" and were printed in Jacksonville by the Vance Printing Company.

Dr. Collins is the present Editor of the Journal of the Florida Medical Association.

At that meeting the oration of Dr. J. Harrison Hodges of Gainesville entitled "Medicine, A Progressive and Courageous Profession" was a detailed and inspiring account of the heroes of medicine from Hippocrates to McDowell. To support the Committee's use of the word "Journal," the annual Transactions that year consisted of 189 pages printed on slick paper, containing a table of contents, minutes, reports of committees, scientific papers presented, directory of active members, Constitution and By-Laws, and the AMA Code of Medical Ethics. The following year the Transactions were printed at a cost of $195. Although this appears exorbitant, the Committee on Publication thought it reasonable "in view of the quality of paper, the clearness of type and the size of the volume which ran to exactly 200 pages." The committee also suggested that by eliminating repetitious material in next year's Transactions, the savings would be enough to provide each member a copy bound in cloth.

In 1904 at the Annual Meeting on April 20, the delegate from Duval County presented a resolution "to undertake the publishing of a Florida Medical Journal to increase interest for a better grade of scientific work and to promote a better understanding in the medical fraternity." Further along in the Transactions of that 31st meeting, there is a long discourse by the Secretary, Dr. J. D. Fernandez, on the advantages of a state medical journal, making a logical plea that the Association undertake the publication of an official journal. Not until nine years later, however, at the 40th Annual Meeting in Miami was a committee appointed to investigate and report on the possibility of the Association publishing its own journal. The following year, the Committee in its report recommended that "the Association attempt to issue a monthly bulletin or journal, consisting of its transactions or business and the scientific matter presented at its annual meetings and such other scientific papers, news items, abstracts, advertisements, consistent with the wisdom of the Publication Committee." After much

discussion on the floor, the second House of Delegates, on May 14, 1914, adopted a resolution to establish a state medical journal, providing that the Association annually appropriate the sum of $800 toward its maintenance and support.

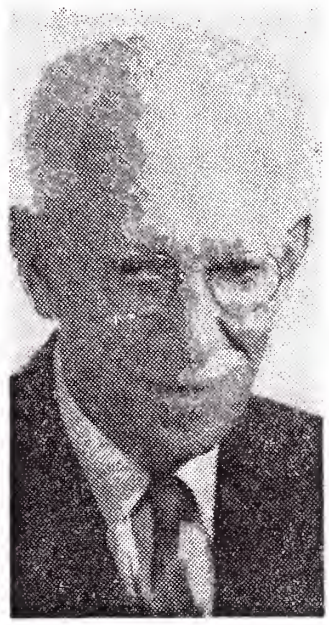
The Journal and Its First Editor

So, on July 18, 1914, there appeared Volume I, No. 1 of the Journal of the Florida Medical Association. The first issue, on pages sized 6½ x 9½ inches, was printed by the Record Company in St. Augustine and mailed from Jacksonville. Along with the proceedings of the 41st annual meeting were several unsigned editorials. The first announced the Journal's birth with hopes of stimulating an interest in organized medicine as there were some 1,177 physicians in Florida but only 474 were FMA members, and only 238 of these belonged to the AMA. A second editorial discussed Florida's inadequate medical laws, and a third described the Journal's advertising policy saying, "the time is soon coming, we hope, when no reputable medical publication would advertise the wares of charlatans and quacks." The next issue contained an editorial appealing to readers to aid in improving the Journal by submitting original contributions and reports of cases. Claude Nolan Cadillac and the Hupmobile Company from Jacksonville paid for advertising as did the medical school in Charleston, S. C. and Tulane in New Orleans. The University of Alabama School of Medicine, located in Mobile, advertised for students. Parke-Davis & Company recommended concentrated antidiphtheric serum and Horlick's Malted Milk was recommended on the front cover of the Journal. Three banks in Jacksonville placed ads, as did Dr. Morse's Sanitorium in Hendersonville, N. C. The National Pathological Laboratory in Chicago advertised Wasserman tests for $5 and gonorrhea diagnosis by the Complement Fixation Test. Rooms were available with rates from $15 to $47 per week at St. Luke's Hospital in Jacksonville. A nurses' training school there was interested in obtaining students.

The first Editor of the Journal, Graham Edward Henson, was born at Henley-on-Thames, England in 1874. At age 15 he was sent to Canada by his family to learn to become a gentleman farmer. He soon found farming not to his liking and so started studying to become a telegraph operator. During this time he obtained a part-time job with a general practitioner who needed an office assistant. The doctor, observing his young assistant to be an eager student, helped him work his way through Wayne State University College of Medicine while continuing at his job. After graduating in 1900, Dr. Henson began general practice in St. Clair, Mich. where he stayed for six years before moving to Crescent City and for five years he was the only physician there. Moving to Jacksonville in 1912 he began writing scientific articles for medical journals and in 1913 published a book on malaria. He became active in FMA affairs and held several offices before being elected Secretary-Treasurer at the Annual Meeting in 1914. With his previous experience and interest in medical writing, it then appeared a logical action to also elect him editor of the newly commissioned Journal. The editorship was for a period of five years with a salary of $300 per year.

In the September Journal was a paper on "Malignant Tumors of the Jaws" by Raymond C. Turck of Jacksonville, a founding member of the American College of Surgeons.

A year's subscription to the Journal was $1 with single copies 15 cents. In the November issue appeared an editorial on "The Tuberculosis Problem" giving the annual U.S. death rate as 200,000. The following year in the February issue the Editor, apparently having little support from his readers, wrote an angry editorial entitled "Do You Want a State Medical Journal?" saying that he had received very few papers for publication. In March the Journal complained of unjust professional taxes, $10 for a state license, $5 for



Dr. Henson

a county license, $5 for a town license and two 25 cent fees for issuance, a total of $20.50, and listing the income of the average American physician as $7,000 per year. At the end of the first year, the Secretary-Editor reported to the Association that the Journal had expended only $291.31 of its appropriated $800. Advertising contracts varying from one month to one year produced $1,959 but apparently production costs were high for the Editor asked that $1 of the $3 dues of each member be appropriated to the funds of the Journal.

In Volume II, No. 1, an ad appeared describing a "Three piece Outfit—$67 to equip your office with footstool and waste receptacle, Baltimore table and instrument cabinet." The first illustration, appearing in this issue, was a cartoon with an editorial on a new cancer program, announcing that the Journal would dedicate one page of each future issue to help educate physicians in the treatment of cancer. The newly organized American Society for the Control of Cancer solicited support of Florida doctors.

In 1916, in February, a long article entitled "The Sex Question in Public Health" appeared in which the question of control of prostitution was explored. One reference was "Prostitution in Europe" by Abraham Flexner and stated that "woman is emancipating herself by a wholesome organization for the improvement of her sex." Pellagra was the subject of another editorial. The proceedings of the 43rd Annual Meeting, held in Arcadia, in 1916 were published with the Editor's report that earnings by the Journal amounted to over $1,000. A letter of advice and commendation from the Cooperative Medical Advertising Bureau, a subsidiary of the AMA, later renamed the State Medical Journal Advertising Bureau, was published. The Journal had joined this organization the preceding year in an attempt to improve its financial status.

In the June 1917 issue, the proceedings of the 44th Annual Meeting were printed with a report that the Journal had not become self-sustaining and that $1.50 of the $3 fee from each member must be given to the Journal instead of the $1 requested at the previous annual meeting. The expenses of the Association included the Secretary-Treasurer and Editor's salary, expenses of the delegate to the AMA and delegates to the Conference of the American Medical Colleges. The Editor, at that time, recommended that the Secretary-Treasurer be bonded by a Surety Company but apparently this was never done. In September 1917, there was an editorial in sympathy with the enthusiastic enlistment of many physicians into the Medical Corps, commending this patriotic fervor. The writer went on to say, however, that the proper duty of many physicians was to remain at their posts at home. Another editorial entitled "Our Journal Facing a Crisis" listed the large number of doctors going into military service and requested those remaining at home to take a more active interest in the affairs of the Journal and the organization. By this time, the FMA membership had grown to 724 and the Journal was being supported more by national advertising; initially it having been financed by local businesses. The Editor apparently did not follow his own advice for soon editorials appeared from Camp Johnson where they had been written in an army tent, reaching St. Augustine by mail.

Because of the difficulties encountered in collecting original articles and getting them to the printer each month, at the Annual Meeting in May 1918, Dr. Henson moved that an acting Secretary-Treasurer and Editor be elected to direct the Journal while he was in service. Dr. E. W. Warren, an obstetrician from Palatka and a past president of FMA, was elected and served as the Journal's second editor until 1919. Returning to Jacksonville from Camp Greenleaf in Tennessee where he had served as the chief medical officer, Dr. Henson again took over the affairs

Dr. Warren

of the Association and publication of the Journal. The Treasurer's report, at the Annual Meeting in 1919, included for the current year an item of $1,031 for "Dues and War Tax," the tax being levied against all those physicians who did not go into military service. Dr. Henson was reelected Secretary-Treasurer and Editor of the Journal. Associate editors were Fred J. Walter of Daytona and R. R. Kime of Lakeland.

At the 46th Annual Meeting, a change was made in the By-Laws, requiring that all papers read by members at the annual meeting be first read before the component county society of which the essayist was a member. Following the annual meeting the paper was then to be forwarded to the Secretary to review with the scientific committee, who would place the paper before the Editor for use in the Journal. The Editor's salary was increased to $600 per year. That year the Journal published a letter from an AMA Council on Medical Education asking for information as to whether Florida had completed a survey, determining what hospitals were qualified to furnish satisfactory internship training and also what was being done by the FMA to provide for the relief of the aged or physically incapacitated physicians and members of their families. In 1921 in the July issue were listed members of the first Board of Medical Examiners who were appointed by Governor Hardy from among names submitted by an FMA committee. They included James M. Jackson from Miami and E. G. Peek from Ocala. In December 1921 a long editorial discussing "Why Florida Could Not Reciprocate" was in the form of a letter replying to an out-of-state doctor asking the question. In 1923 a business depression affected the Journal's revenue and its original material had to be curtailed. The annual report in 1924 showed the earnings from advertising amounted to $2,477 while printing costs had been $2,051. At the Annual Meeting that year it was recommended that an audit of business affairs be made by a certified public accountant. Dr. Henson was reelected Secretary-Treasurer and Editor of the Journal for the third time. The size of the Journal was changed from 6½ x 9½ to a larger 7 x 10 size, beginning with the July issue (Volume X, No. I).

There was a noticeable absence of editorials in Volume XI, sometimes the space being filled with "Publisher's Notes" which, though unsigned, appear to have been written by the Assistant Editor, Shaler Richardson.

Dr. Richardson, Third Editor

At the Annual Meeting in 1925, without any explanation, Shaler Richardson was nominated and elected Secretary-Treasurer and Editor of the Journal.

In Orlando, on November 29, 1925, the FMA executive committee assembled for a called meeting. Present were G. H. Edwards and J. D. Love of the executive committee; President J. S. McEwan and newly elected Secretary-Treasurer-Editor, Shaler Richardson. It was disclosed that when the books and accounts of the Association and Journal had been turned over to the present Secretary-Editor, the liabilities in bills payable amounted to approximately $4,386.86, this being the amount due the Record Printing Company and covered for the most part by a note given by the previous Secretary-Editor. Bills receivable, which consisted of unpaid membership dues and advertising bills amounted to approximately $1,002. Further liabilities consisted of unfulfilled advertising contracts resulting from three unpublished issues of the Journal. It was decided in the best interests of the Association not to publish the three issues, so long in arrears, but to either refund to advertisers their claims on the Journal

Dr. Richardson

or to carry the advertising for three months of the current fiscal year. The newly elected Secretary-Editor was confronted with the discouraging task of attempting to publish monthly editions of the Journal with very meager assets. This was rendered more discouraging through recently increased cost of printing plus a somewhat enlarged Journal. With a determination to meet the new indebtedness and to continue publication without incurring new financial obligations, he did not draw the salary due him. It further appears that he never accepted any salary. In order to continue publication throughout the fiscal year, the executive committee, with approval of the major officers of the Association, obtained a $2,500 note of credit from the Florida National Bank of Jacksonville. An expressed wish of the new Secretary-Editor was that in the business interests of the Association a manager be employed for the Journal. The salary was to be secured through the offer of the Secretary-Editor who donated his monthly salary for this purpose.

Dr. Richardson, born in Lake Charles, La. on February 27, 1891, the son of a physician, graduated from Vanderbilt University School of Medicine in 1913. Serving a two year internship in Memphis, he too entered the Medical Corps of the U.S. Army serving from 1917 until 1919 and for four years afterward he trained at the New York Eye and Ear Infirmary. Entering the practice of ophthalmology in 1922 in Jacksonville, he was a mature 34-year-old physician when elected Secretary-Treasurer and Editor of the Journal, but had been active in FMA for less than three years.

Stewart G. Thompson, D.P.H., Director of Vital Statistics for the Florida State Board of Health, was appointed Business Manager beginning January 1, 1926, and from June 1937, when made Managing Director of the Association and Managing Editor of the Journal, until his death on April 23, 1953, Dr. Thompson served in this dual capacity. In the April 1926 issue a report from the State Health Officer reviewed the number of smallpox cases in the state and appealed to doctors to preach and perform vaccinations. The Proceedings of the Annual Meeting on May 5-6, in Gainesville appeared in the May Journal. One motion to change the By-Laws deleting the Editor as an elected officer as well as providing for a nominating committee was brought before the Association but was not adopted. "Spinal Puncture as Treatment in Cranial Fractures" by Frederick Bowen and Harold Van Schaick of Jacksonville appeared in that issue.

In 1927 in the wake of the prosperity boom, the Association had over 1,000 members. Dade County held an undisputed lead with 170 members that year but Duval outdistanced Dade the next year by a small margin of four. Excellent scientific papers, written by practicing physicians, appeared regularly. The cover of the Journal was a heavy blue paper with the table of contents at the top and below an advertisement recommending ephedrine hydrochloride for the treatment of asthma and hay fever. Papers on the medical and surgical treatment of hyperthyroidism were common. Original articles on the diagnosis and treatment of tuberculosis appeared in several issues. "Gastric Syphilis" was the title of one paper that year.

In the April 1929 issue the Proceedings of the 56th Annual Meeting held in St. Augustine were published. The Editor and Business Manager must have burned the midnight oil to get the 38 pages in form to the printer in St. Augustine to mail to the members, all the while trying to beat the deadline with original material for the next month's Journal. In the September issue an editorial described a newly created specialty, "Aviation Medicine." A paper on leprosy by Dr. J. L. Kirby-Smith gave case reports of 25 personal cases. Illustrations were vivid.

In July the next year, at the urging of the Editor and Business Manager, there was a Woman's Auxiliary page with Mrs. Edward Jelks as State Editor and a message from the Auxiliary president, Mrs. J. Ralston Wells of Daytona Beach, who said, ". . . if we can aid in keeping organized medicine free from personal internal disagreements by furthering good fellowship, the various prevalent cults will find an added barrier to their attacks."

Advertising and Scientific Papers

Inside the June 1931 issue the American Optical Company, in a full page ad, displayed the new "Ful-Vue" frames for men while the Southeastern Optical Company, in another full page ad, displayed their "Hy-Clingswell" deluxe frames. An article on the medicolegal status of railway surgeons appeared in this issue. "Cystocele and Retrocele," with pen and ink illustrations of surgical technique, by Walter C. Jones of Miami was an interesting and well written scientific paper. A paper on "Perforated Gastric and Duodenal

Ulcers" by Eugene G. Peek of Ocala explained his method of treatment. An editorial outlining the pros and cons of having a president-elect for FMA appeared followed by an editorial against the chiropractic cult.

In April 1932 Dr. J. S. Turberville of Century reported a series of 365 cases of appendicitis. Another paper estimated 20% hookworm disease in southern children. A list of FMA past presidents, with the names of those serving from 1874 to 1884 missing, was followed by a request to the reader for information to complete the list. In December that year the first editorial extolled the virtues of treating paresis by means of an induced attack of malaria.

Published in the May 1934 issue were the Proceedings of the 61st Annual Meeting in Jacksonville, April 30-May 1-2. With Florida still struggling in an economic depression from the rash of the post-World War I building boom, at this Annual Meeting the executive committee discussed a recommendation to merge the Journal with the publication printed by the medical societies of Georgia and Alabama. The Editor, reelected at this meeting, logically and emotionally, led an argument against such a proposal and it was rejected.

In January 1937, Parke Davis & Company advertised Haliver Oil with Viosterol for the treatment of rickets while Mead Johnson & Company's ad suggested Oleum Percomorphum. Also in that issue there appeared a paper which said that the "extremely trying times and uncertainties" are bringing nearer "our deadly and surely approaching enemy, state medicine." The solution was fee-for-professional services to indigents paid for by Government subsidy.

In 1938 a full page ad for Chesterfield cigarettes graced the back cover of the Journal, and another full page ad inside stated that three out of four smokers' coughs were cleared completely by changing to Philip Morris.

In 1938, Edward D. Solomon, a Baptist minister and owner of Convention Press, and his son, Crawford began printing the Journal and have continued to do so for the past 35 years. That same year the executive committee approved the publication of a medical directory, and in the February issue of the Journal was the statement: "Every effort will be made to have this new Medical Directory for Florida in the mail before the annual convention in Miami next year." Prior to this, the membership roster had annually been printed in the February issue.

As the By-Laws required that the Editor serve for a period of five years, at the 66th Annual Meeting in 1939 the Editor was nominated and reelected unanimously. In June 1939 the Journal reprinted an article wherein a federal court recognized the significance of medical ethics for the protection of the public in the case of John P. Brinkley's libel and damage suit against Morris Fishbein, M.D. A verdict had been returned in favor of Dr. Fishbein, an outstanding spokesman for organized medicine and a long time editor of the Journal of the American Medical Association.

In 1941 Mrs. Edith B. Hill of Tampa, with much experience in medical writing was engaged to edit original papers after they had been accepted by the Committee on Publication. She is fondly remembered by many fledgling authors (including the present Editor) whose works she corrected and improved. At the Annual Meeting that year in Jacksonville, hotel room rates were $3 single. Richard Fleming of Miami presented a paper on "Surgical Treatment of Extensive Cancers of the Skin," illustrated with lantern slides, and Gordon H. Ira of Jacksonville talked on "Coronary Thrombosis." This was discussed by Franz Stewart of Miami. In the May Journal the Editor, writing on old age said, "So long as a man is doing something worthwhile and means something to the world, he is young."

Beginning with the January issue in 1942 the coarse blue paper cover was replaced with a slick white paper again containing the table of contents in bright blue. A more modern style of type was used and color was added. More often this was in advertisements but when submitted and when the budget permitted, color also appeared in original articles. In the Journal that month it was reported that Florida had become the 47th state to require by law that silver nitrate be used by those in attendance at childbirth for the purpose of preventing ophthalmia neonatorium. With the nation at war a long editorial explained the need for doctors to enroll with the Procurement and Assignment Service to prevent being called to active duty as noncommissioned officers.

In the March Journal a two page spread, announcing the Annual Meeting, illustrated with pictures of the hotel and city was separated by an inserted page printed in red ink stating that the Palm Beach Biltmore Hotel served notice they were closing because of poor business conditions. A last minute change moved the meet-

ing to the Hollywood Beach Hotel. At the Annual Meeting, the Editor, in his report, sang the age old song of increasing costs of publication and declining revenue. By attempting to improve the contents he hoped to secure more advertising, and to offset the rising cost of paper stock, he purchased a year's supply in advance. Completing his report he solicited constructive criticism. The cost of printing the Journal and Directory for the year had been $7,780 while revenue from advertising amounted to $5,285.

In 1943, another World War was absconding with many Florida physicians, and restricted travel and hotel accommodations made it difficult to carry on the affairs of the Association. Shortage of paper stock and lack of free time compounded the chores of the Editor and Managing Editor, but an issue was published every month, with one exception.

On the cover of the April Journal was the following: "Notice—This Journal is dated April instead of March. The date of issue has been advanced one month, but the mailing schedule remains unchanged. Explanation on page 436." Turning to page 436, one reads: "This year the March Journal has been dated April. This has been done to advance the date of the Journal one month. The reason is obvious. The Journal is mailed about the 25th of the month and often does not reach its readers until the end of the month; therefore, according to the date on the cover it is practically a month late when it is received. Under this new arrangement, the April issue will be mailed the latter part of March, and will be available for reading during the month of April." There is no mention in later issues of whether any reader wrote the Editor complaining about not receiving a Journal in March. As far as can be determined, with the exception of the three issues in 1925 and this omission in 1943, The Journal has not missed appearing each month in its 60 years.

With the country fighting on two fronts, the 70th Annual Meeting in April 1943 had a program centered about the war with its first address entitled "Medical Stewardship in War and Peace."

An editorial appearing in October, soliciting scientific papers, mentioned several factors as being responsible for the dearth of original Journal articles: no scientific papers presented at the 69th Annual Meeting, absence of district medical meetings, many regular contributors in the Armed Forces and physicians at home overworked. Also listed were the names of 74 successful applicants out of 82 physicians who passed the Florida State Board's medical examinations that year. In December, a JAMA article was reprinted hoping to arouse opposition to the Wagner-Murray-Dingell bill "designed to form a complete revolution of medical practice in the United States."

Dr. Pearson, Fourth Editor

At the Annual Meeting in 1944, in his president's address, Eugene G. Peek Sr. said, "It is my conviction that some form of group insurance for hospitalization should be agreed upon that would be acceptable to the Association. If we do not adopt a suitable plan, one not of our choosing and with features we should doubtless deplore is likely to be forced upon us." At the election of officers the established custom of combining the position of Secretary-Treasurer and Editor was discontinued when Robert B. McIver of Jacksonville was elected Secretary-Treasurer and Homer L. Pearson of Miami, a past president, Editor. In the June issue, the new Editor persuaded FMA president, John R. Boling to begin a monthly feature article and since that time this has been continued by other editors as the President's Page. Associate Editors were Webster Merritt from Jacksonville, Frank C. Metzger from Tampa,

Dr. Pearson

Lloyd Netto from West Palm Beach and Ralph Sappenfield, a major in the U.S. Medical Corps at Drew Field.

Dr. Pearson, the Journal's fourth Editor, born near the Okefenokee Swamps in Georgia, entered medical school after World War I and was graduated from Emory in 1921. Doing public health work in his home state, followed by a period of general practice in South Carolina, he completed an obstetric-gynecology residency in New York and entered practice in Miami just two years after Dr. Richardson began in Jacksonville. Having similar interests and working together on committees, the third and fourth Editors became close friends. The Editor also served as a delegate to the 95th meeting of the AMA in June 1944 and wrote a review of the meeting critical of the older physician delegates who were not in tune with the times.

For the second time in a little longer than a generation, a Journal Editor (September 1945) paid tribute to returning military physicians for the part they played in serving their country, and welcomed them home. Included in consecutive issues of the remainder of the year were lists of Army, Navy and Marine Corps medical officers returning to every city of Florida.

In the October Journal mention was made of the lifting of gas rationing, ending of bans on conventions and the gradual returning home of medical officers. The FMA Council decided to resume district meetings. Plans were made to convene the 71st Annual Meeting on the following year, it having been cancelled that year, thus explaining why the 100th Annual Meeting occurs during this centennial year.

In the November issue there was announcement of the resignation of Dr. Henry H. Hanson as Health Officer of Florida and the appointment of Wilson T. Sowder, M.D.

In December the Journal carried a Christmas editorial and also a plan for developing prepaid medical care to be financed by loans from each doctor. In February 1946 the Journal announced state approval of a Charter for Medical Service Corporation; so, with the interest, time, influence and money of many private practitioners Blue Cross and Blue Shield began operations in Florida with the support of organized medicine. Also in 1946, the Journal announced a compilation of all the Association Proceedings which had been lost in the Jacksonville fire of May 3, 1901.

Dr. Richardson Again Serves

In 1947 Homer L. Pearson, relinquishing the reins of the Journal, wrote in his final report the age old song of editors everywhere, "that during the past year he had no way of knowing whether he had succeeded or not, for he had not received one word of criticism nor one letter of commendation or encouragement." He expressed thanks to his Associate Editors. At the Annual Meeting, Shaler Richardson, retiring as president of the Association, was nominated by Homer L. Pearson to take back the job as Editor, who said, "Since he has been Editor of the Journal for 20 years at least and it is to his credit that the Journal is what it is today, it is my feeling that he should assume again the responsibilities and privileges, if any, of the editorship of the Journal." A unanimous vote for his reelection was then recorded. An editorial in September 1947 asked the question, "Is There Need for a Law to Legalize Mercy Deaths?" The editorial, unsigned, goes on to say that the physician doesn't need any legal rights but should merely practice the golden rule.

In November 1947 an editorial opposing the Wagner-Murray-Dingell bill said, "It is not socialized medicine that we wish to avoid; that is already here. Private hospitals, research foundations, medical clinics and health insurance plans are to some degree socialized medicine. The question is—do we want government medicine or private collective medicine on a voluntary basis?"

An annual joint report by the Secretary-Treasurer, Samuel M. Day, M.D., and Managing Director, Ernest R. Gibson, in the July 1951 Journal revealed the production cost of the Journal for this fiscal year as $30,342.19 while income from advertising amounted to $29,870 with 40,475 copies having been printed.

Beginning in June 1953, Mr. Gibson became Managing Editor of the Journal serving for six years.

In December 1953 Frank G. Slaughter wrote his first Christmas editorial for the Journal entitled "The Beloved Physician." This began a series which continued for 15 consecutive years.

At the Second House of Delegates in 1954 By-Law changes were approved and the June Journal reported deletion of line 10, Chapter VII, which read, "The Editor shall receive an annual salary of $600 provided that this be paid out of the funds of the Journal." Beneath this was the explanation that the stipulated sums had not been accepted since the early days of the Association

when the positions of Secretary-Treasurer and Editor combined, required much clerical work now being done in the executive office.

In 1955 the Journal was made a part of the Department of Publications with a gradual shift in editorial policy. Three and four or more unsigned editorials appeared every month, written by the Associate Editors, Louis Orr, Joseph H. Lowenthal, Jere W. Annis and Wilson T. Sowder on controversial subjects of their own choosing. Attempts were made to notify FMA members of projects and activities of the Association to encourage their attendance at annual meetings. In the June Journal was noted that Florida "now has 4,530 physicians as compared to 3,025 in 1950, a gain of 49.8 per cent in six years." At the Annual Meeting that year the Board of Past Presidents recommended that the Board of Governors study the matter of poor attendance at the scientific sessions and determine the means of remedying this situation. In August there appeared a picture of FMA's new home in the Riverside section of Jacksonville with an outline of the dedication services. On the cover of the November Journal, for the first time, the Editor used a picture, the photograph of FMA's new home. This same cover was continued for the next 12 months, following which, pictures of doctors, photographed to convey a message, were used. In February the following year there was outlined a long discourse on the new Medicare program which had been passed by Congress the preceding December.

At the 1957 Annual Meeting, the House of Delegates approved a recommendation by President Francis H. Langley that a subcommittee to the Board of Governors be appointed to study and rewrite the Constitution and By-Laws. As this was the first major revision in more than 30 years and a sizable task, the committee requested an extension of time until the Annual Meeting of 1959. The revision, changed to a Charter and By-Laws, said, ... "the Board of Governors would select annually a member of the FMA to serve as Editor." In the old By-Laws the Editor had been listed among the elected officers.

Dr. Moseley, Fifth Editor

In May 1961, Shaler Richardson retired, having served as Editor for 33 years. The President of the Florida Medical Association, Leo M. Wachtel, with approval of the Board of Governors appointed Thad M. Moseley of Jacksonville as Editor Pro Tem. In January 1962 the Board approved him as Editor. Although Dr. Moseley had not previously been a member of the editorial board, he had been Chairman of the Scientific Council whose committees included research, postgraduate education, scientific work and publications. He was thus well prepared for the task to which the ensuing years of excellent Journal publication gave more than adequate evidence. At a time when there was no dearth of excellent scientific material for printing, there was a wholesale withdrawal of advertising by national companies from state medical journals because of alleged questionable advertising value, and so the new Editor's job was twofold. He had to limit the number of excellent scientific contributions published because of circumscribed space, choosing them carefully for value, appeal and interest and he had to increase the amount of advertising to keep the Journal self-supporting. The latter of these tasks he accomplished through the State Medical Journal Advertising Bureau which he served as a member of the Advisory Committee

Dr. Moseley

and as a member of a seven-man Special Committee on Policy. Under his able hand, for the first time in years the Journal began operating in the black.

Several innovations by Dr. Moseley, the Journal's fifth Editor within some 47 years, are noteworthy. Among these were reports from the medical schools on their research activities and the beginning of special issues on the same subject as well as an entire issue each year devoted to medical history. He also was able to persuade various county societies to provide the scientific papers for a special issue, thus getting more practitioners involved and interested. In June 1963 appeared an issue on the diagnosis and treatment of bites of venomous snakes. Vividly illustrated in color, it was obviously a classic and in no time the demand for reprints depleted the reserves. April 1968 saw a second symposium on snakebite treatment. This issue, with beautiful color photographs of poisonous snakes in Florida, again had articles by Newton C. McCullough, M.D., Joseph J. Gennaro, Ph. D. and George W. Gehres from the Division of Health. Wyeth Laboratories aided in publishing both these issues, and with their help a large number of reprints were made, some of which are still available in the FMA office. Assistant Editors were Charles K. Donegan of St. Petersburg; John M. Packard of Pensacola; Oscar W. Freeman of Orlando, and Richard M. Fleming of Miami, who spent many hours reviewing scientific papers submitted for publication.

Dr. Stewart, Sixth Editor

On May 12, 1968 Franz H. Stewart of Miami was appointed the sixth Editor of the Journal bringing to this position a keen wit, inquisitive mind, respect of his colleagues, broad knowledge of medicine and the ability to insert some of each gift into written expression. A poet, artist and polished gentleman, he recognized a good article yet firmly rejected the poor one. During the next two years the Journal covers blossomed from green to multiple colors depicting the scenic beauties of Florida and containing subtle and delightful seasonal messages. Obsessed with the necessity to communicate, the covers described the Editor's belief in beauty, nobility and love of man.

Dr. Stewart's compositions, often pure poetry, were descriptive, beautiful and lucid. His editorial, "Death, A Concept to Remember," published in October 1969, evoked admiration and interest not only from medical readers but also from theological and legal fields as well. When Dr. Stewart resigned in 1970, Gene Nixon, who had been Managing Editor under Dr. Moseley and Dr. Stewart was moved up in the FMA staff to more responsible duties and Louise Rader was named Managing Editor. Without her help this history of the Journal and the entire centennial issue would never have seen the light of day.

In June 1968, Dr. William Straight was made Medical History Editor. With his background as Clinical Professor of Medical History at the University of Miami School of Medicine, he was most interested in the early days of Florida medicine. When Dr. Moseley initiated the idea of a special historical issue in 1965, he persuaded Dr. Straight to continue writing about Florida medical history. With the help of other medical history buffs, a gradually enlarging historical issue has appeared each year. This issue has become a favorite of many readers and was continued every August with the exception of 1973, when all material, effort and money were conserved for the 1974 Centennial Issue. The idea of special issues became so interesting to the present Editor that seven out of 12 publications in one year were so designed, but soon snortings from the budgetary red-ink-dragon stifled most ideas for future special issues.

Dr. Stewart

Dr. Collins, Seventh Editor

In 1970, Jim Cook, FMA president, appointed the present Editor whose only experience had been in publishing his local county medical society bulletin plus two years as Assistant Editor of the Journal. With the increasing division of the practice of medicine among many specialties, in order to have peer review of scientific papers, a new category of editors was developed. The presidents of the various state specialty groups were requested to appoint a member of their society to serve as a consulting editor. To this group of doctors have been referred the original articles and scientific papers sent to the Journal. Many contributions are accepted and others are returned to the authors for rewriting. Poorly written papers are often revised, and accepted papers are edited by Tom Jarvis, a former Managing Editor, now with the Division of Health but who still is quite an asset in publishing the Journal every month. Critical selection by a more equitable review is made as to what items out of all those submitted to the Journal should be published.

In October, 1970, a special issue describing the present eco-catastrophe was coordinated by Robert Ragland. Another issue concerned itself with drug abuse and alcoholism and the following year, special issues were published on medical education in the State of Florida and Physicians Assistants. In the first five months of 1972 the Journal lead all other states in revenue from advertising but inevitably special issues took the extra funds and at the end of the year the Journal was in the red. The cost of paper and printing the Journal continued to rise but in the fall of 1972 the printer was persuaded to add a perfect (square edge) binding so that the title and month could be seen when each issue was filed on a library shelf. A Dean's page appeared each month with the heads of the three state medical schools alternating in presenting their views to the practicing physician.

In the ensuing three and one half years, the problems and purposes of the Journal have changed but little from those faced by Dr. Henson in 1914. The Editor, at the approaching deadline each month, enthusiastically tries to stuff all the papers received into that issue but many more are submitted than can be published. Requests accumulate weekly to include such items as letters, scientific programs, special projects, official notices, actions of the Board of Governors, news of Florida physicians, our medical schools and the Auxiliary as well as the Proceedings of the Annual Meeting. Advertising revenue fluctuates and inevitably some months it fails to cover the cost of printing. The following month something must be left out and this is the day-by-day dilemma of the Editor. What should go in the Journal to catch the eye of the reader and hold it long enough so that he will become increasingly more learned in scientific, socioeconomic, moral and ethical aspects of the practice of medicine? This is the challenge to the Editor and the function of the Journal.

Dr. Collins

In the year 2014 the Journal will be 100 years old and its appearance undoubtedly will be radically different. More Editors, Assistant Editors and Managing Editors will have gone through the same trials and tribulations as the preceding ones. Each will have the same dreams and hopes to effectively communicate to readers and to influence for the better the practicing physician to care for each of his patients as the physician would like to be treated. As long as there is an FMA and as long as there is the Journal, the dreams of all Editors will endure to stimulate and inspire the inquisitive and interested reader.

▶ Dr. Collins, 1503 Oak Street, Jacksonville 32204.

Progress of the Woman's Auxiliary to the FMA

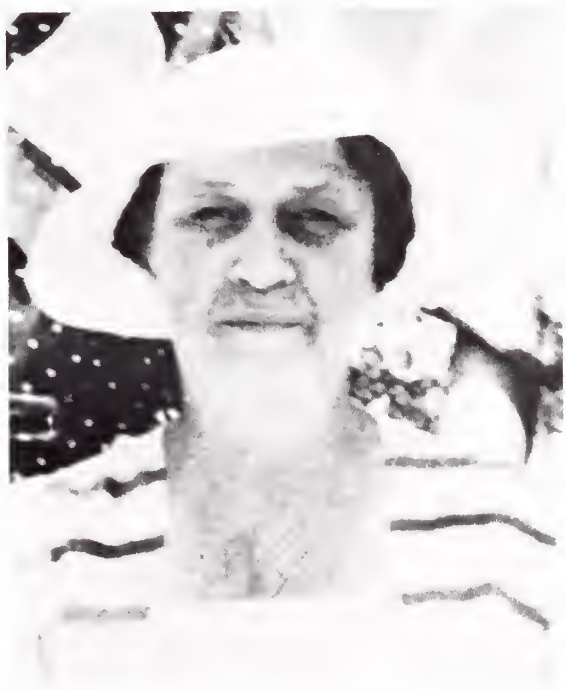
Mrs. James J. DeVito

"How well I remember when they first began to talk about the Woman's Auxiliary in our State Association. No one seemed to know very much about it, and they all seemed rather timid about its possibilities. We finally decided to give it a trial, and as one of our members expressed it, he was willing to try anything once. I think most of us were afraid that you women would take our meetings away from us. Some of the more gallant members agreed to keep a watchful eye on you, and to guide you. Thus was the auspicious beginning of the Woman's Auxiliary of the Florida Medical Association." (From the President's Address to the Woman's Auxiliary by William M. Rowlett, M.D., Tampa 1934.)[1]

Foreword: The vast amount of significant data compiled for a narrative of Auxiliary history would be impossible to summarize in the following article. It would seem irreverent not to include the many painstaking efforts of our earlier sisters, and even more difficult to select but a few of the many events and accomplishments of almost 48 years. The names of countless dedicated women and physicians who have significantly enriched our history should appear, and certainly no less than those 45 women honored to serve as Florida's state presidents. Each of these ladies in her own way provided exemplary leadership, guidance and progressive measures for improvement in humanitarian efforts and assistance to the Florida Medical Association. It is my earnest hope that much of this memorabilia, with supporting facts, figures and illustrations, will be presented in suitable form for the Auxiliary's 50th Anniversary in 1976. For the FMA Centennial Issue it seems more appropriate to highlight those events which may be of interest to the physicians of the FMA.

The request of Tampa's Dr. H. P. Spengler at the 1926 FMA annual meeting in Gainesville provided the necessary spark to fire the enthusiasm of members' wives attending Addressing their luncheon, he told of the work being done by the two year old Georgia State Medical Auxiliary and other state societies.[2] Mrs. Wilburn Lassiter of Gainesville was then elected to serve as the first President with Mrs. A. H. Freeman of Ocala, Vice President; Mrs. H. H. Hannum of Eustis, Secretary-Treasurer, and Mrs. C. U. Tillman of Gainesville as Corresponding Secretary. No further organization work could be accomplished as physician-husbands were anxious to return home, but three executive committee meetings were held before the annual meeting in Palm Beach in 1927. Although the ladies were not idle during this time, difficulties in drafting suitable By-Laws delayed Auxiliary work for another year. Correspondence to county medical societies resulted in the formation of at least eight component auxiliaries, and by the second annual meeting in Tampa in 1928 the auxiliary membership totalled 199. Dues assessed at that time were $1.00 per active member, with 25 cents per capita going to the Woman's Auxiliary to the AMA. The objectives of the FMA Woman's Auxiliary as stated in the initial By-Laws were:

"To extend the aims of the Medical Association, to the wives of the doctors, to other organizations, which looked to advancement in health and education; to assist at entertaining at state,



Mrs. Wilburn Lassiter of Gainesville, first President of the Woman's Auxiliary to the Florida Medical Association.

Mrs. James J. (Catherine) DeVito is Immediate Past President WA/FMA, better known as "Dr. Jim's wife."

county medical society meetings; to promote acquaintance among doctor's families, that close fellowship may exist, and to do such work that may be assigned from time to time by the state medical association".[3] Members soon found many ways to fulfill the purposes adopted in their By-Laws, and county reports at the following annual meeting in St. Augustine in 1929 found the counties Alachua, Dade, Marion, Hillsborough, St. Johns and Volusia busy promoting good will among doctor's families, carrying out charity work, helping needy families, and distributing the AMA's health magazine *Hygeia*. Doctors and their wives traveled some distance to their separate meetings, re-joining for luncheon and dinner. The August 1933 meeting in Polk County took the form of a picnic on Eagle Lake. "No business was transacted, not even by the doctors. Bathing was enjoyed by many and a grand feed was enjoyed by all. We plan to make this picnic an annual affair. Our meetings have brought us much closer together and we have formed wonderful friendships with doctors' families whom we scarcely knew before, so I am sure our organization has been justifiable if for no other reason save that alone".[4]

During the early thirties economic conditions handicapped members in their community endeavors, but they were steadily gaining knowledge and direction in their association with the National Auxiliary and state and county medical associations. FMA President, Dr. Gerry R. Holden, may have been the first to request the aid of the Florida Auxiliary on legislative and other matters pertinent to the profession. The ladies took much pride in fulfilling these requests, and thereafter met regularly with appointed physician-advisors to discuss 'charges' or challenges to be met through joint endeavors.

Members concerned with the overwhelming problems of the thirties held clothing and fund-raising drives to help needy families, and collected sample medicines for indigent hospital patients. Florida's three major health problems, hookworm, malaria and venereal disease were attacked through educational programs, leaflets, etc. An informational folder, entitled "Preventive Medicine From Your Family Physician," compiled by Mrs. J. Ralston Wells, redrafted, and with FMA approval, was printed and distributed throughout the state.

"I will confidentially tell you that the men of our association are banking heavily on you to help us out in our program before the legislature, and counteract the cult propaganda in which they have spent millions of dollars to undermine the greatest science and profession of the world—a science that made it possible for a world war to be fought where millions of soldiers were congregated without the usual war time epidemics—no typhoid, smallpox, tetanus, dysentary, no bubonic plague or yellow fever, a science which made it possible to build the Panama Canal after tropical diseases had defied the ingenuity of man for years, a science that if it today would withdraw all of its adherents, I dare say, there would not be a hundred families left in the State of Florida a year from now."[6]

Physician-advisors were optimistic about the ladies' potential, and regularly inspired members with reports of other state's activities. Drs. Homer L. Pearson and Gordon H. Ira[7] repeatedly stressed the need for more county auxiliaries, and for members to appear before other organizations with programs on cancer prevention, urging the need for health cards for household servants, and fighting legislation unfavorable and even disastrous to the health of citizens. Auxiliary President, Mrs. S. M. Copeland,[8] cautioned her members to be first well-informed on all these matters.

A close liaison existed between the Auxiliary and the Southern Medical Association Auxiliary, and space in the FMA Journal was graciously granted the ladies for their state, county, national and Southern medical auxiliary news. Auxiliary editor, Isabelle Jelks, urged contributors to adhere to the then "ten-day deadline" for monthly publication, using the example of Volusia County's Mrs. J. R. Wells' article, "What it Means to be an Auxiliary Member."[9]

The wartime forties brought a common purpose to national, state and county organizations with defense activities taking preference over all others. Large conventions and meetings were cancelled with only delegates attending to carry on necessary business. The need for medical personnel to serve in Armed Forces left communities with few physicians to carry on the work of many and wives serving over 30,000 hours as Grey Ladies, Red Cross workers, staff assistants in hospitals, canteens, welfare stations, and day nurseries. President Mrs. Frederick W. Krueger, reported to the National Defense Chairman, Mrs. James N. Brawner, a total of $700,000 in the promotion and sale of U. S. War Bonds and Stamps.

In St. Petersburg "The War Program" of the

1944 FMA Annual Meeting was conducted briefly and without any festivities. At an equally brief meeting, Mrs. Krueger sadly reported disbanded or inactive groups, but cited the good work of all physicians' wives. The ladies did manage to hold together the largest number of their auxiliaries, and *Health Institute*[10] days continued to be conducted in some of the counties, funds were provided for the Student Loan (for the son of a physician entering medical school), and a Doctor's Day observance was initiated to be held annually on March 30th.

President Mrs. W. C. Williams of Delray Beach, like her predecessor, had served a two year term in office and her final report at the 1946 annual meeting voiced a concern that members, now free of the demands and stresses of the wartime years, may become apathetic. She cautioned, "the temptation to let someone else take the responsibility is common to us all, but we, as doctors' wives, know that life is not like that." However, while many of the stronger auxiliaries were resuming community health programs and planning for returning physicians, state leaders devoted months attempting to reactivate disbanded units without success. Personal interviews with the county medical society presidents proved the best method of achieving results and by 1949 new life and vigor was evident in the annual report of President Mrs. L. E. Parmley, of Winter Haven.

At the twenty-third annual meeting in Hollywood, 1950, the total auxiliary membership was 884, the largest in its history. Months of legislative campaigning opposing compulsory health insurance was rewarded when members were congratulated by the AMA for a successful campaign resulting in passage of a resolution favoring voluntary health insurance. The AMA's publication, *Hygeia,* had since become *Today's Health* and was finding its way into dentists' offices, beauty shops and other establishments in addition to local schools and libraries. Twenty-two county auxiliaries had been organized by 1955 and membership had more than doubled, reaching 1,700. Programs had increased and diversified to interest the large and small auxiliaries. Nurse recruitment, Future Nurses Clubs, mental health projects joined the list of endeavors, and the Southern Medical Association's request for an annual chronicle of Florida medical history was instituted.

The national auxiliary's request for aid to medical schools was answered with county contributions to the American Medical Education Fund, a fund which later included research as well as education. County medical societies were calling upon their component auxiliaries to assist in immunization projects and health education programs, and the role of the doctor's wife became more effective in the community. The nurse recruitment program was now renamed Health Careers to include the various health-related occupations. The Auxiliary continued to sponsor Future Nurses and Career Clubs and provide scholarship loans, as well as contributing to the American Medical Educational Fund. Also Civil Defense, Traffic Safety, Safety in the Home, and other programs were carried out with great success.

Assisted by the FMA, the state auxiliary conducted its first Fall Conference in 1956, and county leaders were given guidelines to assist in their year's work. President Mrs. Samuel S. Lombardo, reminded members that theirs was not just "another ordinary woman's club to give lip service but a live, invigorating organization infused with the resolve to augment the policies and programs of the medical society from which our birthright was obtained." Auxiliary workshops were held in conjunction with the Association's four district meetings, and the publication *Medaux* and *President's Memos* were distributed to educate the fast growing membership.

An aid to educating the public became a joint endeavor when 100,000 pamphlets "Does your Family Need Protection against the Expense of Illness," prepared by the FMA, were distributed by component auxiliaries at science fairs and throughout Florida's communities. Hospital administrators and other officials declared it the best information compiled to date. The rapport in our husband-wife association thrived with the inspiration and guidance of leaders such as Doctors Roberts, Day, Annis and Zellner and advisors, Drs. Clements, Dowlen and Ira. At the annual meeting in 1960, held in the George Washington Hotel in Jacksonville, President Mrs. W. J. Newcomb of Pensacola regarded her invitation to speak to the House of Delegates as "another step in better relations between the Medical Association and its Auxiliary."

The AMA and its auxiliary met in Miami Beach in 1960 with the ladies' registration doubling that of all previous years; over 2,000 members attended with the Florida delegation serving as host for the various activities. Mrs. Abbott Wilcox Jr., then fourth Vice-President, assisted by

President Mrs. John W. Butcher, headed a committee to make native shell ash trays for the ladies. This convention was the last to be held in any city other than the four usual convention sites.

National and state programs now extended beyond the confines of the United States, and International Health Activities became another project. Sample drugs were collected and sent to needy areas in foreign countries and hospitality was extended to foreign doctors and their families. "Volunteer Physicians in Viet Nam" and Florida physicians' own "Project Honduras" were subjects discussed at the 1966 Fall Conference, and the members' first International Health Bazaar donated proceeds to both of these worthwhile projects.

A new and colorful feature included in the activities of the 1967 annual meeting was the first Annual Art Show, where the entries exhibited proved that physicians' talents were not limited to the "art of medicine." (The categories have since been extended to include sons and daughters of physicians, and an "Editor's Award" to be used for a future Journal cover. Entry fees originally donated to AMA-ERF have recently been directed to the Florida Medical Foundation and earmarked for the Museum of Florida Medical History.)

Legislation continued to be an important part of the Auxiliary's program, and a "Day in the Legislature" was instituted for members to tour the Capitol building in Tallahassee, visit the executive officers, and attend a session in the legislature. In the 1970's loans to deserving students continued, and Health Career Clubs thrived with district meetings and annual conventions by hundreds of students, sponsors, and auxiliary representatives.

Florida doctors sometimes need help. A fact not realized by many, but one of the objectives of the Florida Medical Foundation is to assist needy or medically indigent physicians and their families. Aiding medical students, and promoting medical research are included in the purposes of this non-profit Foundation. In 1969 and 1970 auxiliaries were urged to include this in their programs with fund raising projects, such as the sale of citrus packages, promotion of tours, and direct and memorial contributions to the Foundation. In just a few short years the interest of the auxiliary has benefitted the Foundation tremendously.

The greatest health threat thus far, drug abuse, became a prime object of concern for physicians everywhere. At the request of state and county medical advisors members quickly became more informed and involved with established programs, utilized the national auxiliary guidelines, and aided physician-husbands in an all-out effort to conquer this heartbreaking malady.

A request of the FMA executive committee for help with the Florida Medical Museum resulted in an added project for the state group. Auxiliary members were enlightened about the future needs of a museum in the nation's first hospital before it could become a repository of Florida's medical history.

Community involvement in blood donor and mental health programs, health clinics for children of migrant workers are among the programs which account for the overall success of both county and state auxiliary and the esteem they hold in the national organization.

In the early 1970's the state auxiliary leaders requested the cooperation of the FMA executive committee in putting together these vital programs and expressing the concern of the medical profession for the many health problems. This resulted in a two day conference/workshop cosponsored by the FMA Woman's Auxiliary, the FMA, the Florida Regional Medical Program and the Florida State Department of Health and Education. Featured were the AMA's Dr. Wallace Ann Wesley and the FMA's Dr. Wesley Nock. This conference "indicative of the vital role played by the Auxiliary," proved instrumental in passage by the legislature of comprehensive health and education legislation.

Presently, another chapter is being written in the history of the organization referred to as the "visiting ladies" in 1926. As the membership now nears its 4,000 mark, 1974 seems to promise that the best is yet to come.

Picture if you will the most idyllic setting of the annual meeting of the FMA and its auxiliary in April of 1936: "Somewhere on the Atlantic Ocean aboard the *S.S. Florida,* where meetings were held in the veranda ballroom with its doors and richly draped windows opening on wide decks, and the sun glistening on the white caps of the blue water gave an air to the entire session that will not soon be forgotten."[11]

The growth and enthusiasm of the FMA Auxiliary is evident throughout the state and country. National and regional awards in membership, project participation and contributions increase each year. The past presidents and many other members continue to serve in leadership

roles in this and other state and community organizations, and we can proudly call attention to those Florida women who have served or are currently serving in national auxiliary offices and committees, but the real secret of success has always been the physician's wife who cares for her family and community and upholds the humanitarian ideals of her husband—the physician.

With a wish that the beauty and peace of that long ago gathering may fill your meetings and lives for the next 100 years, the Auxiliary sends its congratulations to the FMA and its membership.

References

1. From the President's Address to the Woman's Auxiliary, William M. Rowlett, M.D., 1934.
2. Auxiliary Minutes Book, 1927-1930 on File in FMA Headquarters.
3. By-Laws Adopted March 1926 by the "Woman's Auxiliary to the Florida State Medical Association."
4. Copied From the Letter of Edith McMurray, Bartow, Florida, April 24, 1933.
5. Many References Have Been Made to This Folder Which May Have Been Titled "A New Deal in Health," but There is no Copy in the Auxiliary Archives to Explain its Contents. (It was printed courtesy of the State Board of Health.)
6. From the President's Address to the Woman's Auxiliary, William M. Rowlett, M.D., 1934.
7. Dr. Homer L. Pearson, FMA Past President and Dr. Gordon H. Ira, Past Chairman of the Medical Advisory Board, Were Two of Many Fine Physicians Guiding the New Organization.
8. Mrs. S. M. Copeland, 1937-38 Auxiliary President (deceased) and Mother of Mary Parham, Wife of W. Harold Parham, FMA Executive Vice President.
9. The Name of Mrs. J. Ralson Wells is Referred to Frequently for her "Untiring Efforts" in Promoting the Purposes Set Forth for the Organization, Serving in Various Capacities Before and After her Term as State President.
10. Open Forums on Public Health Planned in Cooperation With Other Women's Clubs, Physicians, etc.
11. From the Annual Report of Auxiliary President, M. W. E. Veal, Jacksonville, Florida, 1936.

▶ Mrs. DeVito, 208 Inlet Drive, St. Augustine 32084.

Past Presidents WA/FMA

*1926-28	Mrs. Wilburn Lassiter	Gainesville
*1928-29	Mrs. Gail F. Chandler	Miami
*1929-30	Mrs. Mozart A. Liscbkoff	Pensacola
1930-31	Mrs. J. Ralston Wells	Enterprise
1931-32	Mrs. Simon E. Driskell	Jacksonville
*1932-33	Mrs. Leigh F. Robinson	Fort Lauderdale
1933-34	Mrs. Eugene G. Peek Sr.	Ocala
*1934-35	Mrs. Eugene R. McMurray	Bartow
1935-36	Mrs. Ernest W. Veal	Jacksonville
*1936-37	Mrs. Wyman W. Harden	St. Petersburg
*1937-38	Mrs. Silas M. Copeland	Jacksonville
*1938-39	Mrs. Arthur L. Walters	Miami Beach
1939-40	Mrs. Lawrence C. Ingram	Orlando
1940-41	Mrs. Gordon H. Ira Sr.	Jacksonville
1941-42	Mrs. William J. Barge	Miami Shores
1942-43	Mrs. Frederick W. Kreuger	Jacksonville
1943-44	Mrs. Frederick W. Kreuger	Jacksonville
1944-45	Mrs. William C. Williams Jr.	Delray Beach
1945-46	Mrs. William C. Williams Jr.	Delray Beach
1946-47	Mrs. Chester H. Murphy	Bartow
1947-48	Mrs. Leslie M. Jenkins	Miami
1948-49	Mrs. Lee E. Parmley	Winter Haven
1949-50	Mrs. Charles F. Henley	Jacksonville
1950-51	Mrs. James L. Anderson	Miami
1951-52	Mrs. C. Robert DeArmas	Daytona Beach
1952-53	Mrs. Herschel G. Cole	Tampa
1953-54	Mrs. Thomas G. Kenaston Sr.	Cocoa
1954-55	Mrs. Richard F. Stover	Miami
1955-56	Mrs. Samuel S. Lombardo	Jacksonville
1956-57	Mrs. Scottie J. Wilson	Fort Lauderdale
1957-58	Mrs. Perry D. Melvin	Miami
1958-59	Mrs. Lee Rogers Jr.	Rockledge
1959-60	Mrs. Wendell J. Newcomb	Pensacola
1960-61	Mrs. John M. Butcher	Sarasota
1961-62	Mrs. W. Dean Steward	Orlando
1962-63	Mrs. Edward W. Ludwig	Jacksonville
*1963-64	Mrs. Abbott Y. Wilcox Jr.	St. Petersburg
1964-65	Mrs. Willard L. Fitzgerald	Miami
1965-66	Mrs. H. Quillian Jones	Fort Myers
1966-67	Mrs. Allen E. Kuester	Cocoa
1967-68	Mrs. Russell B. Carson	Fort Lauderdale
1968-69	Mrs. Linus W. Hewit	Tampa
1969-70	Mrs. C. H. Gilliland	Gainesville
1970-71	Mrs. Arnold J. Spanjers	Winter Haven
1971-72	Mrs. Wesley S. Nock	Coral Gables
1972-73	Mrs. James J. DeVito	St. Augustine
1973-74	Mrs. William H. Mathews	Jacksonville

* Deceased

Medical Regulation and Organization in Florida

1821-1874

E. Ashby Hammond, Ph.D.

When ceded to the United States by Spain in the summer of 1821, Florida was not a land of good health and great promise. Notwithstanding the optimism of the expansionists, the problems which beset the newly-acquired territory were numerous and troublesome. It is told of John Quincy Adams, Secretary of State under President Monroe, that he dreaded the arrival of the Florida post, "never knowing what strange new problem would spring from the mail bag."[1] James G. Forbes, named by Monroe as United States Marshal for East and West Florida, was appalled at the conditions confronting him. In a letter to the Secretary of State he complained of "the present miserable State of the Province almost inundated by Constant rains and without Commerce or such products which can create it immediately."[2] Less than a month later, as the sickly season ensued, he professed never to have witnessed a less salutary condition "in this Country, than at present when inundation, Consequent sickness, and general distress seems to pervade most classes of the miserable population now residing in it."[3]

Thus from its beginnings the Territory faced health crises consequential of the periodic visitations of deadly fevers endemic to subtropical America, and both its civil and military authorities were sensitive to the necessity of protective measures against the spread of disease. From its inception the territorial government, even in its provisional stages, relied heavily upon the advice and assistance of the medical practitioners in the area, a pattern typical of the American frontier, where all too often the physician was one of the few educated persons at hand.

Medical Licensing

In both Pensacola and St. Augustine, Florida's only urban communities, yellow fever was a deadly contagion and public health measures could not be delayed. It was, therefore, only a matter of days after the official transfer of these towns to the agents of the United States (Pensacola on July 7 and St. Augustine on July 10) until the establishment of provisional governments, both of which featured boards of health headed by reputable physicians. The board of health of St. Augustine, announced on July 16, consisted of Mayor Gabriel W. Perpall; William Travers, alderman; Francis P. Sanchez, merchant; the Reverend Michael Crosby, Roman Catholic priest; and Dr. Richard Murray, health officer.[4]

A more complete roster of public officials for the Corporation of St. Augustine, published on February 1, 1822, reveals a reorganization or at least an extension of public health functions. To the board of health had been added as ex officio members the entire board of aldermen as well as a "resident physician and president of the board of health," the change presumably having been made in the late summer of 1821. A letter of September 27, 1821, John R. Bell, commander of United States troops in St. Augustine, to the acting governor of East Florida, included the following: "The Board of Health, it will be recollected is composed of the City Council with the addition of Dr. Stone who is resident Physician of this City."[5]

The Pensacola experience was similar. On July 19, 1821 Governor Andrew Jackson issued commissions creating the temporary government of the city. At the top of the list was his friend of long standing, Dr. James C. Bronaugh, who had served as an army surgeon in the War of 1812, was later assistant surgeon-general, and was General Jackson's personal physician during some of the Indian campaigns. With obvious confidence in his ability, the governor had named him resident physician and president of the board of health.[6] For the post of health officer, Jackson's appointee was Dr. John V. D. Voorhees. As was true in St. Augustine, Pensacola's board of health consisted of the resident physician and the members of the city council.[7]

Within a week after its establishment the Pensacola board of health held two meetings. At the first, on July 21, with Dr. Bronaugh presiding and Dr. John Brosnahan among the members present,

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a general medical ordinance was passed. Utilizing the broad power conferred upon it by the governor, the board assigned unto itself the total control of the licensing of physicians who would practice in Pensacola and vicinity. Applications to practice were to be submitted to the board and "if two thirds of the board are satisfied that he (the applicant) is qualified, and that he is of correct moral character, he shall be licensed accordingly on paying to the Secretary the sum of five dollars."[8] The board further ordained that every physician practicing in Pensacola would be subject to a fine of $300 for failure to report any case of yellow, bilious, pestilential or contagious fever under his care.

Two days later, at its second meeting, the board of health found itself in the somewhat awkward situation or dubious procedure of issuing licenses to practice to two of its own members, Dr. Bronaugh and Dr. Brosnahan. As the newspaper reported it, "Dr. James C. Bronaugh, President of the Board of Health, being desirous of applying for permission to practice medicine, George Bowie, Esq. was called to the chair . . . whereupon James C. Bronaugh, M.D. presented his diploma from the University of Pennsylvania, which was deemed sufficient, and was thereupon licensed to practice medicine in the City of Pensacola. Dr. Bronaugh then resumed the chair." The board then examined the credentials of Dr. Brosnahan, a prominent citizen and practitioner in Pensacola until his death in 1871, and licensed him to practice. Similarly Dr. John V. D. Voorhees, having presented his medical diploma from the "University of New York," was granted a license.[9] Some six weeks later the board examined the application of a fourth physician, Dr. Christopher Y. Fonda, and voted its approval.[10]

This examining and licensing function of the board of health was soon terminated, however, probably at the urging of its nonmedical members. In a meeting of September 6, 1821, the board ordained the establishment of a "Board of Medical Censors" consisting of the resident physician of Pensacola, the health officer (Dr. Voorhees), and Drs. Elliott and Merrill of the United States army post in Pensacola, which would examine and license physicians. The board of health also recommended that the two army physicians be commissioned as members of the board of health, along with Dr. Voorhees, health officer. And just to make certain that the citizens of Pensacola understood the degree of authority vested in the board, Governor Jackson on the same day, "in order to remove all doubts respecting the powers of the Board of Health," decreed that "the Board of Health possess free power to regulate the practice of medicine in the city of Pensacola, and to establish rules and regulations for that purpose, and grant licenses to such persons as may be found qualified to practice." He also approved the addition of Drs. Elliott and Merrill to the board."

The St. Augustine newspaper was less diligent in reporting the transactions of the board of health of that city. Although no mention is made of the licensing function, it must be assumed that such a responsibility devolved upon the board since the general ordinances for St. Augustine and Pensacola were identical. St. Augustine's board was empowered to "make, and from time to time to alter, such laws and regulations as they may deem necessary to ensure the health of the city." Only three references to its transactions during those first critical months have actually survived. On November 23, Dr. Stone was instructed to declare the epidemic at an end,[12] while earlier it was reported to have issued two resolutions demanding the removal of the old Spanish Hospital from the center of the city.[13]

But licensed or not some seven or eight physicians are believed to have practiced in St. Augustine and its environs in 1821.[14] For a city of less than 2,000 persons this represents a high doctor to patient ratio.

Quarantine Regulations

As important as regulation of membership in the medical profession may have been it was superseded by the acuteness of the problems imposed by yellow fever and kindred ailments.[15] Local newspapers, inclined throughout the 19th century to minimize or even to conceal the seriousness of local epidemics, provide only slight knowledge of the onslaughts of the fevers, but there is sufficient evidence to show that both St. Augustine and Pensacola were hard hit in the summer and fall of 1821. Dr. Benjamin B. Strobel of Charleston, who visited St. Augustine late in 1839 to investigate the epidemic then prevailing in the city preparatory to writing a treatise on yellow fever, tells of interviews with Dr. Simmons, a fellow South Carolinian, who was present in the sickness of 1821. Simmons recalled St. Augustine as a filthy place, due in some measure to the failure of Spaniards, anticipating removal to Cuba, to maintain a semblance of police regulation. Such conditions, he thought, in combination with the

exceptional heat and heavy rains of the summer, explained the severity of the siege. The fever, he noted, had begun in September and continued until December, prompting a number of desperate experiments on the part of the practitioners attempting to bring it under control.[16]

Boards of health of both cities moved quickly to implement the broad powers granted to them by Governor Jackson. Quarantine grounds were designated and health officers appointed. Time was short, for the "sickly season" was upon them almost before the transactions of the cession were complete. In September the board of health of Pensacola passed a hurriedly drafted ordinance setting forth in detail the quarantine arrangements for the harbor, specifying the duties of both resident physician and health officer as well as the fines and penalties for violations of the health code.[17] Effective immediately the health officer would meet all incoming vessels at the quarantine area to prevent, as it was stated, "the introduction of contagious diseases into the city." The resident physician entered upon his tasks of visiting the sick, visiting quarantined vessels, directing the disposal of rubbish, enforcing health regulations, and bringing to the attention of the board of health all matters which required their attention and official action.

In the following year, 1822, the appointed Legislative Council held its first session in Pensacola, convening on July 22, in spite of the delayed arrival of some members of the East Florida delegation. At the sitting on the following day Dr. Bronaugh of Pensacola was elected president of the body. Its agenda was overwhelming in that its problems were in many instances unique and guidelines did not exist. Before the end of August its work had been interrupted by the appearance of yellow fever which signaled a general exodus from the city. The entire Legislative Council left the city for what was hoped would be the safer locale of Don Manuel Gonzalez' plantation some sixteen miles out.[18] It was there that the Council hurriedly drafted and passed a lengthy act "to provide against the introduction of contagious diseases, and for the establishment of Boards of Health in the Cities of Pensacola and St. Augustine," to which Governor Duval affixed his signature on September 2, which, ironically, was the day of Dr. Bronaugh's death.[19]

This was an elaborately constructed law which included a mass of details designed to cover any conceivable eventuality. Into it was incorporated every major feature of the Jackson ordinance of the previous year, to which were added specifications not necessarily applicable to the particular needs of either city. It provided, for example, for a daily meeting of the boards of health from June 1 through October 31. Each board was to consist of all the city aldermen, a resident physician and, in addition, four members to be appointed by the governor on January 1 each year. To the health staff in each city was to be added a quarantine steward who must reside on the quarantine grounds, and two health wardens with power to arrest and confine. A reduction to absurdity, one might say, but such was the public fear and climate of the moment.

In June 1823 the Legislative Council, working in a more relaxed atmosphere, enacted a measure repealing the entire law of 1822 and, in its stead, empowering the boards of health in both cities "to pass all quarantine laws, and to make such regulations for the preservation of the health of their respective cities as may seem to them good and proper." The measure also reconstituted the boards of health to consist of the aldermen and "a resident Physician, to be appointed annually by the Mayor and Aldermen, on the first day of May. The Resident Physician shall be ex officio President of the board of health."[20] It seems significant that this act was the first to have been passed at the 1823 session. Interestingly, however, for reasons undetermined it was rejected by Governor Duval; possibly he was reluctant to allow the appointive power to slip from his hands. Nevertheless his veto was immediately overridden by the requisite majority of the Council. As the season of epidemics arrived in 1824, the city of St. Augustine, utilizing its prerogative, sought to meet the threat with a well-designed ordinance setting up a rigid quarantine and specifying in detail the responsibilities of all health personnel.[21]

Within the next decade or so, as other towns sought charters of incorporation, the experience of St. Augustine and Pensacola provided the basic patterns for public health and medical regulation. For the inland towns the charters did not enunciate the details of regulation and for obvious reasons included no provisions for quarantine. Thus in the cases of Marianna (Nov. 5, 1828), Quincy (Nov. 21, 1828), Chattahoochee (Jan. 24, 1834), and Newnansville (Feb. 25, 1839) all health regulation was discretionary with the town councils. On the other hand, the charters of Magnolia (Nov. 12, 1828), Key West (Nov. 10, 1828) St. Joseph (Feb. 12, 1836), and St. Marks (Feb. 5, 1837) reveal in each instance a vital

concern for quarantine regulation and set forth the duties, responsibilities and powers of the councils to impose quarantines and pass ordinances for the protection of the health of the inhabitants.[22]

Medical Board

As time passed it became increasingly apparent that the licensing of medical practitioners for the territory could not continue to rest exclusively with the boards of health of St. Augustine and Pensacola. Settlers were arriving in Florida in ever-increasing numbers and certain counties, especially those lying between the Suwannee and Apalachicola Rivers, were experiencing notable population growth. Of these, Gadsden, Leon, Jefferson, Madison, and Jackson (the last lying west of the Apalachicola) were becoming the area of plantations and large farms, many of which were owned by physicians or planters whose sons became physicians. Late in 1824 the Legislative Council provided that every person desirous of practicing medicine in the territory must file in the office of the clerk of the county court in the county in which he intended to practice a diploma issued by "some college or university," together with a certificate of moral character, whereupon a license would be granted. The flexibility of certification standards, however, may be measured by the further provision that, failing to produce a diploma, the would-be practitioner could still qualify by filing with the clerk a certificate showing that he had studied physic or surgery for two years, either at a college or under the supervision of a reputable physician or surgeon. That fact having been established, any two judges of the county could at their discretion grant a license to practice. Fraudulent certification could be punished by a fine not to exceed $500.[23]

The act of 1824 remained in force for less than four years. It was superseded on January 5, 1828 by an act conceived, it would at a glance appear, to raise certification standards and centralize controls over the medical profession. The paucity of information on the discussions leading to its enactment does not permit a safe judgment as to why the previous act was deemed inadequate. One may surmise that conscientious physicians, especially those in the Tallahassee area, feared that clerks in the several counties could not be trusted to maintain acceptable standards. Anyway, the new law established a medical board for the entire territory, charging it with the responsibility of examining all candidates-to-practice in Florida and issuing licenses to those qualified. Named to the board by the act itself were the following, all physicians: Richard Weightman and William H. Simmons of St. Augustine, Robert A. Lacy of Key West, William D. Price and Lewis Willis of Tallahassee, Malcolm Nicholson of Gadsden County, William P. Hort of Jackson County, and Christopher Y. Fonda and John Brosnahan of Pensacola.

The medical board was to sit annually in Tallahassee commencing its session on the second Monday in December, with any three members constituting a quorum. One may well question the effectiveness of controls, however, when he reads further that any applicant presenting a diploma from some "regularly established medical university within the United States, and a certificate of moral character shall, in all instances" be licensed without further examination. Equally lax was the provision that whenever the board was not in session each individual member could examine an applicant and issue a license to practice, such action being subject to review at the next regular session of the board. The cost of the license was fixed at $10 to be appropriated as the board saw fit. No provision was made for reimbursing board members for their expenditures.[24] An amending act of the following November changed the time of the annual session to the third Monday in October and added the following members to the board: Alfred Guthrie of St. Augustine, Henry S. Waterhouse of Key West, Thomas Munroe of Tallahassee, John T. J. Wilson of Gadsden County, and John Porter Lockhart and Harris B. Crews of Jackson County, all of them physicians. The members previously appointed were retained.[25]

For all the efforts of a few dedicated physicians to organize a viable professional society, and notwithstanding the apparent willingness of the Legislative Council to provide the legal foundations for sorely-needed public health controls and a responsible licensing system for medical practitioners, the results were minimal. One can only assume that the hardships of travel and the difficulty of communication between and among the scattered settlements, spread sparsely from Pensacola around the Keys to Fernandina, discouraged most of the doctors from active participation in the organization. Besides, there were doubtless some practitioners of dubious qualification who did not wish to invite exposure to professional scrutiny. Whatever the explanation, the legislative act of February 10, 1831 repealing the acts of 1828 gives

evidence of the failure of the efforts at professional self-regulation and represents, to some degree, a retrogression into a more relaxed and haphazard system of health and medical regulation. The more significant portion of the act of 1831 follows:[26]

> . . . any individual desirous of practising medicine and surgery, in the *Territory of Florida,* shall be enabled to do so, by pursuing one of the following methods . . . First, he (shall) file in the office of the county court of the county in which he may intend to reside, a diploma from some medical college . . . Secondly, or he shall file in the office of the aforesaid, a certificate, signed by at least two practising physicians, residing in this Territory, who shall be regular graduates of some medical college . . . Thirdly, or he shall file in the office aforesaid, a certificate signed by some professor of a medical college, that they (sic) have attended one course of lectures in some one of the medical colleges aforesaid, and also a certificate from one of the physicians aforesaid.

One has only to recall the veritable rash of medical colleges making their appearance in many parts of the United States during the decades of the 1820's and 1830's to appreciate the possible consequences of this act.

Corporate Organization

Having thus terminated the life of state medical board staffed with responsible physicians from the more populous parts of the Territory, and having committed the licensing of physicians to the caprices of county clerks, or at best to the discretion of a mere couple of physicians residing anywhere within the Territory, the Legislative Council was to take no further significant action on matters of health and medicine for the rest of the territorial period. In the meantime, physicians followed the normal patterns of professional behavior characteristic of the general practitioner in rural America in the 19th century. Doctor-patient relationships were highly personalized. Most physicians were doubtless humanitarian in spirit, dedicated to the relief of human suffering; it was the era of the all-night vigil at the bedside of the sick. Many physicians became the civic leaders in their communities; most became involved in the political life of their localities. Newspapers of the times report much participation of physicians in party organizations of their towns and counties. A few turned to intellectual pursuits as naturalists and popularizers of science; some, such as Dr. John Gorrie of Apalachicola, wrote columns of medical advice.[27] On the other hand, there can be little doubt that some were woefully unprepared, even by the standards of the times, to practice their craft; some were surely insensitive to the ethical restrictions imposed on members of their profession. And yet, in the unrestrictive milieu created by such acts as that of 1831, little could be done to disbar the incompetent or the outright quack.

For the years, 1831 to 1845, territorial legislation on medical matters was of little importance. Occasional items, dealing with such matters as inoculation for smallpox, fees for attendance upon prisoners, protection of physicians from attachment of their professional equipment, and organization of medical staffs in the militia were considered from time to time; little more. On the other hand the medical faculties of some Florida counties and towns were mindful of their public responsibility for maintaining ethical behavior and acceptable standards of practice among their members. In 1833, for example, a group of Tallahassee physicians published a list of fees which they regarded as reasonable, pledging themselves to charge no fee in excess of the published price.[28]

Throughout these years of seeming indifference to the medical needs of the Territory, however, there were always physicians who recognized the necessity for some kind of corporate organization of practitioners committed to the highest ideals of their profession: the advancement of medical science, protection of public health, decent standards of practice, service as the advisory voice of medicine in the councils of towns as well as in the state's legislative body. It is difficult to determine from whence the impetus to action came. It can be shown through census schedules and the innumerable professional cards in the columns of the newspapers in the 1840's that many physicians were entering Florida each year. Some of these, recent graduates of medical colleges, surely brought with them high ideals and deep concern for their medical commitments. Others had no doubt been affiliated with professional associations elsewhere and were cognizant of the benefits to be derived therefrom.

Whatever the motivations might have been, the consequences became evident by early 1848 when a small group of physicians from Leon and the surrounding counties gathered in Quincy on May 14, 15, for the purpose of establishing a state medical society. Present were:

Gadsden Co.—Richard Jarrot, Jean H. Verdier, William Booth, James L. Shields and David L. White
Leon Co.—James S. Bond, George W. Betton and James Henry Randolph
Jefferson Co.—John L. Call and B. Waller Taylor
Calhoun Co.—J. M. G. Hunter
Jackson Co.—E. D. DeGraffenreid

The Quincy Times of May 20, 1848 reported:

"The professors of Medicine of this State held a Convention in this place on Monday and Tuesday last. The assemblage was not too large, but we think their action will have a good effect upon the profession." At the session on the 15th, Dr. Booth was elected president pro-tem pending the meeting of the legislature in the following December when it was expected that a charter would be approved and a permanent medical organization would be launched.[29] Elected as interim vice-presidents were DeGraffenreid, Shields, Bond, Taylor and White, who were to serve also as a corresponding committee. As its final action the society resolved to meet in Tallahassee on the first Monday in January, 1849, by which date it was assumed the legislature would have authorized the incorporation of the society. It was expected that on receipt of the proper invitations and on being apprised of the objectives of the group, physicians from all parts of the state would be persuaded to come to Tallahassee for an auspicious beginning for the organization.

As the time for the Tallahassee convention drew near the corresponding committee appealed to their colleagues throughout the state by personal letters and newpaper columns. About November 18, several newpapers published the persuasive plea of Dr. David L. White, prominent Gadsden County physician and committee member, to his "professional brethren" urging upon them the necessity for a State Medical Society. His arguments were cogent and clear, while his assessment of the state of medical practice in rural America during that era is a revealing document which warrants reprinting at this point.[30]

To all Physicians of Standing in the Profession

The subscriber, one of the Vice Presidents, and of the corresponding committee, would beg leave to call the attention of his professional brethren, and urge upon them, the necessity of a State Medical Society. Convinced, he is, of the importance of such an institution at the present moment; it would tend to elevate the profession and to vast improvement in the healing art. Far removed, as we are here, from access to large libraries, and intercourse with learned, able and practical men of high standing in the profession, we are called upon from high considerations of responsibility to unite in exertions to free the profession from the aspersions cast upon it by Charlatans and superficial men.

While it is acknowledged that European physicians do surpass, in classical education, and in variety, depth, and extent of erudition, many of us—yet in acuteness of penetration and promptness of remedial resource, in the use of means that are accurately adapted to the end, in the treatment of the diseases of our climate, we are perhaps not as deficient as many suppose. Necessity is the strongest incentive to exertion, and in all its tendencies is original and inventive. A large proportion of those who toil in the profession among us, are so situated as to command few of the ordinary advantages enjoyed in large and populous cities by the profession, and they are hence driven mainly upon their own resources. Our minds not enfeebled by an undue reverence for authority of system, we are, I hope, open to the reception of new impressions and eliciting new lights. It is important that we watch, interrogate and scrutinize nature as exhibited in the morbid state. Thus did Hippocrates, Sydenham, and others, whose names are immortalized on the pages of medical history—As medicine principally consists in the knowledge of facts progressively accumulated, it results, that our endeavors ought to be diligently and incessantly directed to this object.

Let us, therefore, unite our best efforts and endeavors to introduce into the study and practice of physic, that high and refined degree of reason and philosophy, without which it is so far from affording useful aid, that it becomes in reality a public scourge.

Every member of our society is interested in the high standing of our profession, for every person has health either to preserve or to regain.

The uncertainty and even inutility of medicine is the favorite cant among men who enjoy robust health, among incurable patients, and among that portion of our fraternity who avail themselves of it as a shelter from the reproach of their ignorance and blunders. With all its imperfections and uncertainty, medicine can still justly claim a body of principles and doctrines eminently entitled to confidence. If we could suppose it to be otherwise, and believe it incapable of being reduced to rules and principles, it would be unlike all other arts; those who practice it would degenerate into a herd of visionaries, empirics and imposters, and instead of being protected, they ought not even be tolerated by a wise government. If it were possible, therefore, to set medicine aside as a science and an art, it would still be impossible to suppress the instinctive feelings of mankind, and of consequence a much greater number of victims would be sacrificed to the protensions of ignorance and cupidity. Permit me to say, in conclusion, the standard of hope is planted on the citadel of death—let us, then as a body, on the first Monday in January next, in the city of Tallahassee, assemble and unite in organizing, in order to counteract the ravages of death.

David L. White, Sr.

The General Assembly convened on November 27. On November 28 the Sentinel of Tallahassee noted that application was being made to the Assembly requesting an act to incorporate a Medical Society of the State of Florida. The bill was drafted under the title, An Act Relating to Practitioners of Medicine, and entrusted to Representative Nicholas A. Long of Jackson County for presentation to the House of Representatives. It was announced on December 13 and first read by Long on the 22nd. Its second reading came on the following day. Immediately following its third and final reading on December 28, a member moved referral to the committee of the whole for the consideration of a special amendment thereto. The motion lost 19 to 12 with Mr. Long voting against. Without further delay the vote on the bill was called for. It went down to defeat by a margin of 18 to 12 with Long voting for. Thus died the bill in the House just four days prior to the convention of physicians set for January 1.[31] If any out-of-town physicians actually arrived in Tallahassee neither of the city's newspapers took any notice of them, nor did they note the defeat of the bill.[32]

In the absence of any real evidence as to reasons for the defeat of the medical bill one is left to ponder the action of the House. Reports of the Quincy meeting in the previous May offer no clues as to the provisions of the expected charter. They only emphasized "the great necessity of a State Medical Society, for the protection of ours, and the rights of the people."[33] Indications are that the bill brought to the House by Representative Long was in fact drafted by members of the Quincy group, possibly by the corresponding committee in consultation with Long. One may assume that any forthcoming charter would have been acceptable to the medical faculty and that Long, having committed himself to the support of the bill, was opposed to any amendment which might have reduced its effectiveness or altered its contents. One might guess that the House majority deemed the public good would not best be served by placing the broad controls of medical licensing and practice in the hands of the physicians themselves. Perhaps, for reasons not discernible, they preferred to retain the lax and permissive licensing system authorized by the act of 1831. Since legislative debate and opinion for this period is seldom a matter of record, the questions here raised cannot now be answered.

Then came a surprise move in the Florida Senate, a move which could almost be branded as conspiratorial. On the day prior to the defeat of the medical bill by the House, Senator Robert J. Floyd of Gadsden County gave notice of his intention to introduce in the Senate a bill entitled, An Act to Incorporate the Florida Medical Society.[34] Instead, on December 29, the day following the defeat of the medical bill in the House, Floyd read a bill entitled, An Act to Incorporate the Medical Board of Florida. Waiving their rules of procedure the Senate permitted immediate second and third readings, then proceeded to approve the bill by a margin of 13 to 1, with only Senator William A. Forward, then of St. Augustine, opposed. It passed the House unanimously on January 3 and received the Governor's approval on the 6th.[35]

It would appear, then, that Floyd had intended to introduce the bill still under consideration in the House, assuming that it would gain House approval, although it was not normal procedure to announce such intention until final action had been taken by the body in which the bill had initiated. When the fate of the House bill was made known Senator Floyd seems to have offered a substitute bill and, to judge from its ambiguities and careless wording, a hastily drawn one. Since no copy of the House bill has been located, comparisons which would disclose the objections raised in the House are not possible. It is interesting indeed that the House should on December 28 have defeated the one 18 to 12, and on January 3 accepted the other unanimously.

The Senate bill was in several respects unusual. Its first section includes the names of ten members of the medical profession who, with "their associates and successors," were constituted "a body corporate, under the name and style of the Medical Board of Florida."[36] It may certainly be inferred that all licensed physicians practicing in the State of Florida were eligible for membership on the board, an inference confirmed in the fifth section of the act which states that "all licensed physicians in this State shall be entitled to admission into the said Medical Board, upon complying with the constitution and by-laws prescribing the terms of admission, unless two-thirds of the whole society shall object to such admission." The employment of the word, "society," in this instance appears to be of some significance. The legislature had in fact created a professional association and not a mere administrative board, whatever its limitations. It is especially noteworthy that six of the physicians present at the Quincy Convention — Jarrot, DeGraffenreid, Booth, Hunter, Betton and Taylor — were omitted from the list of those specifically named to the board. If all qualified physicians were eligible for admission, how can these omissions be accounted for?

More perplexing, however, is section four, which empowered the "corporation" to appoint "five members of the said board to examine all applicants for license to practice medicine" and "to perform the same duties that are required by the existing laws of this State, and who may grant licenses to such applicants, and the form of such licenses shall be adopted by a majority of said board." Then followed the astonishing proviso, "That nothing herein shall prevent any physician in this State from proceeding in the *manner now directed by law for the procuring a license to practice medicine,*"[37] an obvious reference to the act of 1831, which was still in force. One can only conclude that notwithstanding the creation of a medical board, association or society, authorized to examine applicants and issue licenses to practice, any applicant so desiring could still

elect to obtain his license from any county clerk within the state. The new medical board seemed doomed from the day of its creation.

Adding further substance to the idea that Florida's legislature, particularly the House, was not disposed to incorporate an effective medical society was its stance at the session of 1850-51 when a Senate bill designed to bring the law of 1831 into consonance with the Medical Board Act of 1849 was approved in the Senate by a vote of 14 to 1 only to be tabled after its second reading in the House.[38] Having thus made it clear that the examination and licensing of physicians was not to be entrusted exclusively to the discretion of a committee of members of the medical board, the House proceeded to pass an act and a resolution neither of which could have been calculated to endear it to the members of the medical profession. By the act the House voted to grant a special license to practice medicine to one George W. Andres of Benton County (soon to become Hernando County), a practitioner of the Thomsonian Method, a system of botanics already in disrepute among regular physicians.[39] The resolution of reference here, which immediately passed both houses, stated that "the Medical Board of this State be, and they are hereby required, to establish a fee bill for medical services, and report the same, if practicable, to this, if not, to the next General Assembly." This order, which could scarcely have been favorably received, seems to have been ignored by the practitioners.

For the balance of the antebellum period the Florida legislature displayed little interest in the medical profession, nor did the physicians themselves seriously attempt to organize a professional association. The politics of the 1850's consumed much of their energies, and the burning issues of the prewar years served to divide them into hostile factions. Most Florida physicians had been in the Whig camp, but with the breakup of their party after 1852, they gradually came to embrace the cause of secession and the Confederacy. With the coming of the War many found their places in military medicine.

As for the Medical Board of 1849, there is no evidence that it ever became a viable professional society. It seems instead to have languished for lack of support, and from its inception to have been hopelessly moribund.[40] Infrequently the legislature dealt with minor medical matters such as setting fee rates for physicians attending prisoners,[41] compensation to physicians attending coroners' inquests, occasional relief for physicians in the service of the state, and tightening the laws of quarantine. It was not the time for progressive legislation in such areas as public health and medical education.[42] Aside from such secondary concerns, little was accomplished. Florida must therefore await the arrival of another group of conscientious practitioners who, under the leadership of Dr. Abel S. Baldwin of Jacksonville, would meet in that city in 1874 and launch the Medical Association whose centennial we celebrate this year. Even then it must wait another seven years for its legislature to enact a measure assuring reasonable standards of medical practice to its practitioners and its citizens. This latter was one of the achievements of the legislative session of 1881.

Notes

1. James, Marquis: The Life of Andrew Jackson (New York, 1938), p. 321.
2. Carter, Clarence, ed.: The Territorial Papers of the United States, 26 vols. (Washington 1934-1962), XXII, 136. Letter of July 29, 1821. To be cited as Territorial Papers in subsequent references.
3. Ibid., XXII, 171. Forbes to John Q. Adams, from St. Augustine, August 18, 1821.
4. Ibid: XXII, 121, 434. Dr. Murray, a native of Ireland, was still a subject of the English monarch, George IV. He was to be naturalized in the following month.
5. Ibid., XXII, 216. This was Dr. Micah Stone, a native of Massachusetts, about whom only a few facts are known. As president of the board of health he had issued a proclamation on November 24, 1821 announcing that the yellow fever epidemic was at an end. See St. Augustine Florida Gazette, November 24, 1821. His death came just eleven days later, probably from the fever, and his age given was 55. Ibid., December 10, 1821 For the vacancy the board of health chose Dr. William H. Simmons, a native of South Carolina and a man destined to serve both St. Augustine and the Territory with distinction as physician and member of the Legislative Council. Simmons declined to serve, however, and the position was given to Dr. J. C. P. McMahon. See Territorial Papers, XXII, 339.
6. Ibid., XXII, 131. For a biographical note on Dr. Bronaugh see ibid., p. 73. Dr. Bronaugh, a Virginian by birth, was also appointed to Florida's first legislative council which met in Pensacola in July, 1822. He was immediately chosen to preside over that body and doubtless wielded considerable influence over its deliberations. He announced as candidate for delegate from Florida in the elections of the fall of 1822, only to fall victim of yellow fever on Sept. 2, a few days prior to the adjournment of the council. It was a melancholy coincidence that both Bronaugh and his St. Augustine counterpart died of fever soon after assuming their respective posts.
7. The Pensacola Floridian, Aug. 18, 1821. Dr Voorhees was also dead before June 15, 1822.
8. Ibid.
9. Ibid. Although Dr. Brosnahan is known to have been a native of New York, the newspaper omitted mention of the medical college from which he held a degree. I have no further identification of the "University of New York."
10. Ibid., Sept. 8, 1821.
11. Ibid. The Dr. Elliott mentioned in this instance was Moses H. Elliott, surgeon to the 4th Infantry Regiment then occupying Pensacola. Dr. Merrill was Ayers P. Merrill, medical officer at Ft. Barrancas. Elliott entered private practice in Pensacola in 1822; he was dead before March 8, 1823. See ibid., issues of May 4, 1822 and March 8, 1823.
12. Florida Gazette, Nov. 24, 1821.
13. Territorial Papers, XXII, 214, 219.
14. Straight, William M.: "The Yellow Jack," Journal of the Florida Medical Association, LVIII, (Aug. 1971), 33. Dr. Straight has identified the following: Richard Murray, Micah Stone, Charles N. McCoskry, G. E. DeSaussure, William H. Simmons, Edward R. Gibson and Richard Weightman. To this list should be added the name of Dr. J. J. Owen, formerly of Baltimore, who died on December 5, 1821, aged 55. His death occurred on the same day as Dr. Stone's.
15. Ibid. pp. 31-47.
16. Strohel, B. B.: An Essay on the Subject of Yellow Fever, Charleston, 1840, p. 139.
17. The Floridian, Sept. 29, 1821.

18. The disruption and near-panic which beset Pensacola in August 1822 cannot be documented as completely as one might wish. The Floridian ceased publication with its issue of August which carried a dire warning from Dr. Bronaugh as to the deadliness of the epidemic. Dr. Bronaugh was himself a victim of the disease within two weeks, as was Dr. E. B. Foster and possibly Dr. M. H. Elliott. In a early issue of the new Floridian, which resumed publication on March 8, 1823, the ravages of the epidemic may be measured by the great number of notices inserted by executors of the estates of deceased inhabitants, among them the three physicians mentioned above. Ibid., March 29, 1823.
19. Territorial Papers, XXII, 531. For the statute itself see Acts of the Legislative Council of the Territory of Florida, 1st sess., 1822, pp. 55-56, cited hereinafter as Acts, Leg. Council.
20. Ibid., 2nd sess., 1823, pp. 4-5.
21. East Florida Herald, Sept. 25, 1824. The ordinance was passed on Sept. 1, 1824.
22. Dates in parentheses are dates of incorporation. The acts of incorporation may be seen in the Acts of the Legislative Council, Territory of Florida, for the respective years. The charters of some towns were, of course, reissued occasionally.
23. Acts, Leg. Council, 3rd sess., 1824, p. 287.
24. Ibid., 6th sess., 1827-28, pp. 46-49.
25. Ibid., 7th sess., 1828, pp. 258-60. Act of Nov., 18, 1828.
26. Duval, John P.: Compilation of the Public Acts of the Legislative Council of the Territory of Florida, Tallahassee, 1839, p. 368.
27. Apalachicola Commercial Advertizer, June 15, 1844.
28. The physicians responsible for the list were John A. Craig, Lewis Willis, John B. Taylor, J. M. Randolph and John McLemore. Their effort was unavailing, however, in that it immediately provoked the wrath of certain physicians who had not been a party to the schedule of fees and who countered with their own list of reduced prices. See the Tallahassee *Floridian*, issues of Feb. 2, 9, 16, and March 30, 1833, for lists and the controversy arising from their publication.
29. The Quincy Times, May 20, 1848, published a full account of the convention including the balloting for officers and the sixteen resolutions which were passed.
30. The Tallahassee Floridian, Nov. 18, 1848.
31. A Journal of the Proceedings of the House of Representatives of the Territory of Florida, 4th sess., 1848-49, pp. 107-8. Cited hereinafter as House Jour.
32. Fortunately the files of both Tallahassee newspapers, the Sentinel and the Floridian (known after Jan. 1, 1849 as the Floridian and Journal), for the months here under consideration are preserved without missing issues.
33. Quincy Times, May 20, 1848.
34. A Journal of the Proceedings of the Senate of the General Assembly of the State of Florida, 4th sess. (1848), p. 118. Cited hereinafter as Senate Jour.
35. Ibid., p. 129. Forward, a former speaker of the House, moved to Tallahassee a short time later. See also The Acts and Resolutions of the General Assembly of the State of Florida, 4th sess. (1848-49), pp. 74-75.
36. These physicians, with their counties of residence, were: James H. Randolph (Leon), John S. Bond (Leon), George W. Call (Leon), Jas. L. Shields (Gadsden), David L. White (Gadsden), John (Jean) H. Verdier (Gadsden), John L. Call (Jefferson), Benj. J. J. Mitchell (Madison), B. J. Scriven (Leon), and John L. Crawford (Wakulla).
37. The italics have been added. The act of 1831 had neither been repealed nor amended.
38. Senate Jour., 5th sess. (1850-51), pp. 39, 44, 48, 50, 55-56. House Jour. 5th sess. (1850-51), pp. 73, 83, 90. The motion to table was offered by Rep. John Milton of Jackson Co.
39. Ibid., pp. 53, 72, 92. Senate Jour., 5th sess. pp. 205, 217, 229. This bill passed the Senate on January 7, 1851 with Senator John L. Crawford a highly respected physician of Wakulla County among those opposing. The Thomsonian System originated with Samuel Thomson, a New England blacksmith, who patented the method in 1813. Although it gained respectability in some quarters, even gaining the support of a few physicians, by mid-century it was generally branded as base quackery.
40. My searches in the surviving newspapers of the 1850's provide no evidence that the Board of Health was ever either an active administrative agency of the State or an operational professional association. One might well ask why the Legislative Assembly took no subsequent action to enforce compliance with its 1849 act, especially on the matter of a licensing committee, or to alter its provisions. It is my belief that a number of vexatious problems which were to culminate in secession and war simply crowded other matters into the background. Perhaps also there was general indifference among both legislators and physicians.
41. Acts and Resolutions, Leg Assembly, 5th sess. p. 130.
42. Reference to such acts may be found in ibid., 7th sess. (1855) p. 55; ibid., 10th sess. (1860) pp. 59-60.

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The Tallahassee College of Medicine and Surgery

Sara B. Straight

"Tallahassee, the capitol of the State, 'the floral city of the flowery South,' is one of the loveliest places in all America. It is built upon the broad, gently rolling surface of a high hill, surrounded on all sides by other lovely hills and deep valleys, for it is in a region of hills, valleys, and lakes."[1] Such was to become the home of the Tallahassee College of Medicine and Surgery, Florida's first medical school.

Tallahassee had long been the center of interest in education. After a lengthy process of trial and error, its citizens solved their school problems by establishing the West Florida Seminary on January 1, 1857. This Seminary, which charged no tuition, was open to girls as well as boys in 1858. It was from this beginning that the Florida University came into being in 1883. According to the charter, the University was to consist of five schools but only two came into being: the Literary College which had been in existence as the West Florida Seminary and the Tallahassee College of Medicine and Surgery.

Although all historical sources do not agree, it is generally believed that creation and development of this University, particularly the medical branch were due to the efforts of Dr. John Kost, Dean and later Chancellor and Chairman of the Board of Regents. Historians refer to Dr. Kost as "just appearing" in Tallahassee in 1883. However, a further look at his record shows that he came well prepared. Born in Pennsylvania on April 6, 1818, he began his medical studies at the age of 16 in Ohio. He was licensed to practice, started a program of reform in medical practice, and soon became Professor of Materia Medica and Therapeutics at the University of Cincinnati. Thereafter he held chairs in several other schools such as: Professor at the Medical College, Worcester, Massachusetts; Professor of Chemistry, Geology and Zoology at Adrian College, Adrian, Michigan (1863-1866); and President of Marshall College in Illinois in 1867.[2] He was also at one time Chancellor of Heidelberg University (Tiffin, Ohio).

Aside from distinguishing himself as an educator, Dr. Kost made a national and international reputation as the author of a score or more works. These included books on materia medica, theory and practice of medicine and also a textbook on medical jurisprudence for medical and law colleges. In 1868 he bought the building and plant of the Adrian newspaper, Expositor, and carried on its business for about a year when the paper was merged with the Adrian Times.[3]

He has been credited with the discovery of several alkaloids and resinoids which have found their way into materia medica. Among these is podophyllin which he extracted from the mandrake root. This substance is still in use as a cytotoxic agent in the topical treatment of condylomata acuminata.

Two other aspects of this many-faceted personality were his 20 years as a Methodist minister[4] and his enthusiastic curio collecting which resulted in one of the finest privately owned museums in the country. Dr. Kost spent much of

John Kost, A.M., M.D., LL.D. (Courtesy of The New York Academy of Medicine, New York).

his fortune on the purchase of rare specimens for this museum at Adrian, Michigan.

After his sojourn in Florida, he returned to his home in Adrian and spent his last years in retirement working on his last and reputedly his best writing, a book entitled, "Human Destiny." On January 10, 1904, death ended his 86 years as a physician, scientist, educator, minister and author.[5]

The medical school was founded as an incorporated stock company with an initial capital of $60,000 and given the authority to increase this to the amount of $80,000. Since 10% of this was allotted for equipment, the college had a fine anatomical museum, a well-stocked museum of natural history, and much assorted chemical and laboratory equipment.

The medical college made an agreement with the literary college (West Florida Seminary) by which it was to use one of their two buildings. The building was a "commodious brick edifice, situated on an elevated site in the western part of Tallahassee, with ample grounds shaded by a grove of native pines. The building is of fine architectural appearance, with a frontistyle of stately white columns supporting an entablature and gable above the second story. The building contains two large lecture halls, and eight additional rooms of convenient sizes, well-suited for the medical department with its museums and apparatus."[6]

Faculty and Students

According to the "First Annual Announcement (1883-1884)," the medical college boasted of thorough instruction in all branches of medicine. The Announcement goes on to state, "besides a very full faculty of men experienced not only in teaching but also in long medical and surgical practice, there are also the most ample material appliances." This Announcement lists the medical faculty:

J. Kost, A.M., M.D., LL.D., Dean
Professor of the Institutes of Medicine
V. A. Baker, M.D.,
Professor of Theory and Practice of Medicine
H. G. Griffith, A.M., M.D.,
Professor of Anatomy and Surgery
H. S. Greeno, A.M., M.D.,
Professor of Orthopedic and Clinical Surgery
J. E. Cummins, M.D.,
Professor of Obstetrics and Diseases of Women and Children
M. Veenboer, A.M., M.D.,
Professor of Materia Medica and Therapeutics
W. F. Dickerman,
Professor of Chemistry and Botany
Judge W. P. Byrd, A.M.,
Professor of Medical Jurisprudence[7]

There is some evidence that the physicians of Tallahassee also served on the faculty. Finally, there were provisions for an Instructor in Taxidermy and Embalming and a Demonstrator of Anatomy.

Both males and females of suitable age, good morals and ability to pay the fees were eligible for admission. The cost of attending the medical school was tabulated thus:

Aggregate amount of all tickets	$60
Matriculation	5
Examination for Graduation	25
Diploma—no charge	
Clinics—no charge	

The Announcement notes, "at a citizen's meeting pledges were made, by various persons, of good accommodation for student's boarding and lodging, for from $12 to $15 per month." Cheaper lodging could be had by "the club plan" and some details of the cost of food are noted. Students were invited to bring whatever textbooks they had on

West Florida Seminary Building used by The Tallahassee College of Medicine and Surgery 1883-1885. (Courtesy of State Photographic Archives, Strozier Library, Florida State University).

hand "in the various branches of Medical, Surgical and Obstetrical studies." The Announcement also notes that the fee ($25) for the "examination for degrees" was returned to unsuccessful candidates.

The first session began November 20, 1883, and ended March 20, 1884, with the examinations beginning on March 12th. According to the Calendar of 1884-1885, there were 79 students in attendance at the University the first year. The Calendar notes there were eight medical students, one each from Leon County, Key West, and Georgia, and five from Michigan. Unfortunately the names of these students are not given. Much of the school's success in attracting students as well as faculty was attributed to "the charming climate of Tallahassee." (In the First Anouncement is a long paragraph given to selling the idea of coming to medical school in sunny Florida. It further states, "a very large attendance from the Northern States is confidently expected.")

Final examinations were conducted by the assembled faculty during the last week of the lecture course. "Candidates for graduation had to afford evidence of good moral character, possess a good English education (Latin, Greek, German and French being also desirable), as well as, a competent knowledge of the Natural Sciences. The medical requirements are such as may be attained by three years reading on the several medical branches under a competent preceptor; and the attendance of two full courses of lectures, the latter should be in this College."[6] Thus if a student spent three years in reading medicine and had formal instruction for approximately one college semester, he was considered sufficiently prepared for graduation and consequently for professional practice. However, in order to receive his diploma the student had to be approved by the Board of Regents. The College also adopted the precedent of conferring on successful candidates a "University Medical Degree."[8] At the first commencement there were two graduates, but it is not clear whether either of these were from the Tallahassee College of Medicine and Surgery.

Among the young men from Florida who attended the medical school was Leonidas Mosby Anderson. He received two courses of instruction there before taking up practice at Lake Butler and later Jasper. He evidently felt his education was not adequate for in 1896 he studied at the Atlanta Medical College (forerunner of the Emory Medical School) from which he was graduated.[9] Dr. Anderson moved to Lake City in 1907 where he became a well-known physician. He took an avid interest in the medical affairs of the state and served in various offices of the Florida Medical Association, finally becoming its president in 1922. He was the first member to qualify as a Life Member of the Florida Medical Association.

In February 1885 the state legislature recognized the Florida University as the university of the state and designated that it should henceforth be named the University of Florida. Meanwhile at its annual session in the spring of 1885 the Florida Medical Association went on record as not approving the Medical Department of the University of Florida as it was organized in Tallahassee.[10]

It is not clear how long the Florida University existed. The medical school was moved to Jacksonville in the fall of 1885. During its brief sojourn there, Dr. Thomas Osmond Summers served as the Dean of the medical faculty which consisted of eight professors and one demonstrator but of these we know the names of only two: Dr. T. O. Summers and Dr. Richard Berrien Burroughs who was Professor of Clinical Medicine and Diseases of Children.[11] It is not clear whether John Kost was still a member of the faculty when the school moved to Jacksonville. He next turns up "in the spring of 1888, as the State Geologist and Director of the newly founded Experiment Station and Agricultural College at Lake City."[10]

Some time during the year 1886, the Tallahassee College of Medicine and Surgery/Medical Department of the University of Florida went out of existence thus bringing to an end "the most ambitious and most visionary attempt ever made to establish in Florida an institution of higher learning."[6]

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The School of Medicine of the University of Miami

An Historical Brief

E. M. Papper, M.D. and Bernard J. Fogel, M.D.

In 1925 when the University of Miami was founded, one of the declared aims was to organize a medical curriculum. No other educational institution in Florida had offered a medical education since 1886 when the Tallahassee College of Medicine and Surgery had ceased to function after only three years of operation.

The establishment of the School of Medicine at the University of Miami was made possible in 1951 when the Florida state legislature provided for the payment of an operational subsidy for medical students who lived in Florida. University of Miami officials moved rapidly and arranged with the Veterans Administration to lease an unused structure adjacent to the Veterans Administration Hospital which then occupied the old Biltmore Hotel in Coral Gables. Hasty remodeling turned an empty building into classrooms and laboratories for the teaching of the basic sciences. Meanwhile the Dade County Commission agreed to permit county owned Jackson Memorial Hospital to be used as a teaching hospital, and also to construct a new outpatient clinic for teaching during the last two years of medical school. This period was a turbulent one and the details require a longer text than is possible here.

Less than one and one-half years later with 28 students, an Acting Dean and a faculty of four, the School of Medicine opened its doors to the first class in September 1952. Twenty-six students were graduated with M.D. degrees four years later in June 1956. At that time the school was accredited by the Liaison Committee of the Association of American Medical Colleges and the American Medical Association.

After seventeen years separation between the Jackson Memorial Hospital in Miami and the Basic Science Building in Coral Gables, the school was united physically for the first time when the Rosenstiel Medical Sciences Building was opened in August 1969.

Dr. Papper is Dean of the School of Medicine and Vice President for Medical Affairs.

The combination of the new medical sciences building, state and federal support, as well as the addition of a better administrative structure permitted the School of Medicine to begin really significant progress in strengthening all of the preclinical and clinical departments.

Faculty

The School of Medicine in 1973 has a full-time faculty of 531 including many able and outstanding scholars and medical educators in this country. There are also 61 part-time faculty, 864 voluntary faculty and 632 interns and residents. One hundred of our clinical faculty are members of AOA and over a dozen are Markle scholars. An unduly high proportion of the faculty are members of the intellectually "elite" organization in their fields. Recently a Nobel prize winner joined our staff.

The recruitment of an outstanding faculty permitted the School of Medicine to make a significant commitment toward diminishing the physician manpower shortage of Florida and to some degree in the nation. Between 1968 and 1972, the School of Medicine increased its student body from 325 to 531 students or 57%. This year 131 students are in the entering class; this figure does not include the 20 students admitted to advanced standing through our Ph.D.-M.D. program. In 1974 we anticipate graduating 132 students, nearly double the number graduated in 1969.

Students

Despite the fact that the size of the entering class and student body has increased by such a large percentage, the quality of the candidates has improved even more dramatically and is comparable to the student body of the best institutions in the nation. An idea of the academic abilities of the entering student can be obtained by a comparison of the academic record of the accepted students during the past four years. In 1969 less than 50% of the entering class had a grade point

average of 3.0 and the mean was 2.99. In 1973 over 98% of the students have G.P.A. better than 3.0 and the 1973 entering class has a mean G.P.A. which is 3.45. The Medical College Aptitude Test scores in the quantitative and science sections are comparable to the best anywhere. Careful attention is paid via personal interviews and other information to try to assure their quality as compassionate human beings.

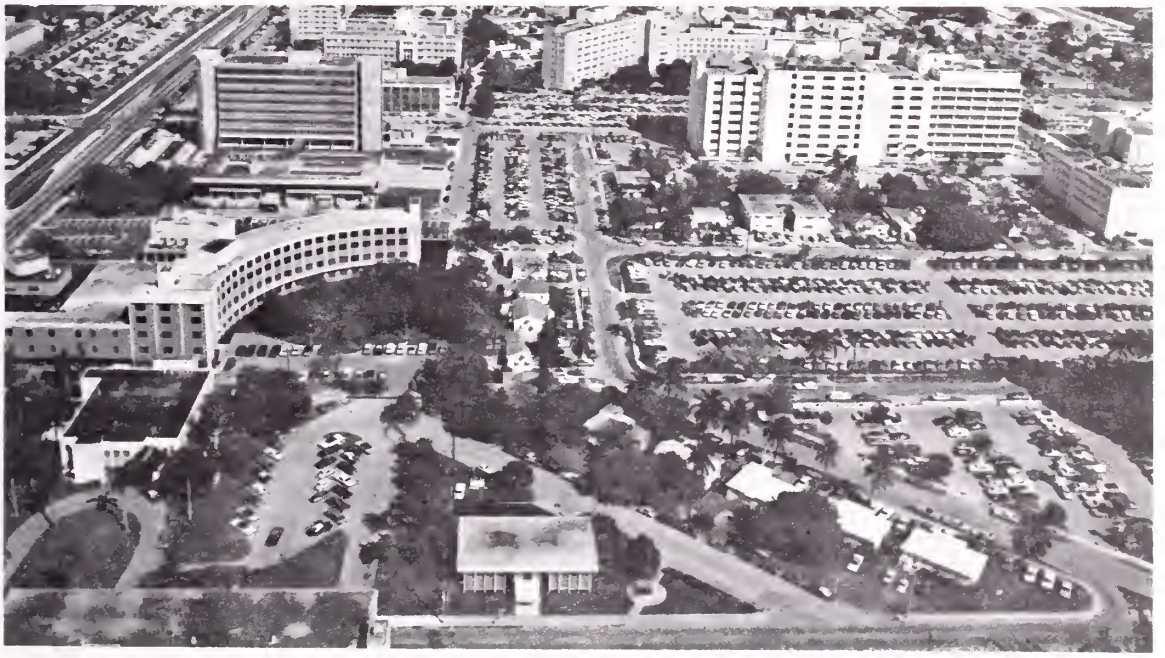
The improved caliber of faculty and student has also permitted the School of Medicine to revise completely its undergraduate curriculum. In July 1973 a 33-month curriculum was introduced experimentally. This new educational program has evolved over a period of some years of planning.

There is virtually no reduction in the preclinical training time. Students still have adequate free time for self-study and ample time to review for all examinations. The beginning date of school was moved up by two and one-half months. During the first four months the students are offered courses in gross anatomy, embryology and basic tissues, biochemistry and an introduction to medicine. In November and December the students have an integrated course in the neurosciences. After a brief Christmas vacation they participate in a three-month program in systemic biology.

A 15-week sophomore core program similar to the one introduced a year ago began in April 1973. Students will have a one month vacation prior to the beginning of their Mechanisms of Disease course. They will be required to pass Part I of the National Boards, as at present, and to have performed adequately prior to promotion to the clinical segment of the accelerated curriculum. The clinical course of study will be unchanged.

In addition to implementation of a 33-month curriculum, the School of Medicine has initiated an innovative educational experiment: the Ph.D.-M.D. program. It is based on the premise that there are many qualified men and women already holding a Ph.D. degree who are capable of going through an accelerated medical program which takes advantage of their scientific knowledge—but does not fore-shorten their clinical education. The program began in 1971 with 20 students. There were 143 applicants in 1971 (six week application period) and 1,041 applicants for the 1972 class. There are approximately 700 applicants for the entering class of 1973. The performance of these students on the National Boards has been exceptionally good. The group's overall performance this June would have placed them third in the United States.

Although the early results seem to be successful, this program is still viewed as an educational experiment. Exceptionally qualified individuals can be trained in an accelerated fashion. They achieve in the traditional manner and the type of contribution these students will make can only be evaluated over the next five to ten years.



The University of Miami School of Medicine—1973

University of Miami School of Medicine
Chronology of Deans
and Vice Presidents for Medical Affairs

Homer F. Marsh, Ph.D.	Acting Dean	Dec. 1952-Dec. 1953
Robert J. Spicer, M.D.	Dean	Dec. 1953-July 1954
Homer F. Marsh, Ph.D.	Dean	July 1954-July 1961
Robert B. Lawson, M.D.	Interim Dean	July 1961-Jan. 1962
Edward W. D. Norton, M.D.	Interim Dean	Jan. 1962-July 1962
Hayden C. Nicholson, M.D.	Dean	July 1962-Dec. 1966
Hayden C. Nicholson, M.D.	V.P. for Med. Affairs and Dean	Jan. 1967-Sept. 1967
W. Dean Warren, M.D.	Dean	Oct. 1967-Jan. 1968
W. Dean Warren, M.D.	V.P. for Med. Affairs and Dean	Feb. 1968-Dec. 1968
Frank Moya, M.D.	Acting Dean	Jan. 1969-Nov. 1969
Emanuel M. Papper, M.D.	V.P. for Med. Affairs and Dean	Dec. 1969-To Date

Facilities

During the first two decades the School of Medicine was fortunate to have significantly improved its physical facilities. In 1959 the county matched federal funds to construct the Medical Research Building which houses the majority of some $14 million in sponsored research programs. In 1962 the Bascom Palmer Eye Institute was built to house the Department of Ophthalmology. It is one of the finest institutions of its kind and internationally recognized. A new Veterans Administration Hospital was opened in the heart of the Medical Center campus in 1968. In August 1969 the first five floors of the Rosenstiel Medical Science Building were completed. The $6 million eight story Mailman Center for Child Development was dedicated and opened in March 1971. The Calder Memorial Library was completed in January 1972. Last year $3 million expansion of the University of Miami Hospital and Clinics/National Children's Cardiac Hospital was finished. In 1973 the top three floors of the Rosenstiel Medical Science Building and the west pavillion were also completed.

In two decades the School of Medicine moved from rented quarters in the old V.A. Hospital to buildings costing nearly $30 million. This figure does not include the costs of the new Veterans Administration Hospital or the Jackson Memorial Hospital which will undergo major renovation during the next four years. Despite the reduction in construction funds from the federal government, the School of Medicine has broken ground for a new Eye Institute Hospital supported entirely by private funds. This unit will incorporate the most modern concepts of ophthalmologic research as well as patient care.

The School of Medicine is justifiably proud of its contribution in the field of biomedical research. Last year (1972-73) over $17 million in federal grants and contracts for research and research-oriented training were awarded to members of the faculty. Although some of these funds represent commitments that will continue for future years, the level of support was second only to that of Duke University in the southeast. The actual amount of the funds awarded for 1971-72 was $14,700,000.

The School of Medicine has also been one of the few schools awarded funds to establish a Cancer Research Center. The school received significant recognition when the National Heart and Lung Institute awarded $2,184,500 to establish a specialized Center for Research in Atherosclerosis. This Center at the University of Miami is directing its efforts toward the prevention or delay of the onset of clinical manifestations of heart disease.

In 1973 the Liaison Committee on Medical Education of the American Medical Association-American Association of Medical Colleges reported after a vigorous inspection that the School of Medicine was of the highest quality. There seems, nevertheless, to be no dearth of challenge, problem solving, or opportunity for the faculty and the students. The school will always aspire to demonstrate compassion for fellow human beings, to attain the highest qualifications in the faculty and students, and to develop means whereby intellectuality and human relations can be combined to improve the health of the citizens of Florida and ultimately of people everywhere.

▶ Dr. Papper, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami 33152.

Origin and Development of University of Florida College of Medicine

Mark V. Barrow, M.D., Ph.D., and Chandler A. Stetson, M.D.

The University of Florida College of Medicine is now 17 years old. Begun in the early 1950's, completed in 1956, and graduating its first medical class in 1960, the first state-supported medical school in Florida continues to grow and expand. It, therefore, seems appropriate to review the history of this medical school at intervals. The last review which considered the initial phases of development was published in this Journal in August 1968.[1]

Florida's educational history dates back to the mid-19th century when the new state established two seminaries which later became state universities, one in Tallahassee and the other in Gainesville. During World War II, Dr. John J. Tigert recognized the need for a medical school in the University of Florida and also urged that it be at Gainesville because of the central location and benefits to be derived from an affiliation with the existing University. In 1943 the state legislature recommended establishment of a school of medicine, dentistry and pharmacy in Florida but did not provide funds or stipulate a specific location. This recommendation was not implemented and Florida continued to obtain its physicians from outside the state. Students from Florida who desired to obtain an M.D. degree were sent to several universities including Duke, Emory, Tulane and Vanderbilt. The Florida legislature's subsidy provided $1,500 per year for the education of each of 55 students.

When Dr. J. Hillis Miller became the fourth president of the University in 1947, he envisioned a large health center complex in his inaugural address. Because of his interest and a citizen committee's recommendations and an unfavorable ratio of one doctor to 1,100 citizens, the legislature authorized a survey of health services in Florida to study the needs and location and cost of a medical school. This study was undertaken by Vernon W. Lippard, then Dean of the School of Medicine at Louisiana State University, and was completed in 1949. As the result of this report, in April 1949 the state legislature authorized the creation and establishment of a medical school and nursing school at the University of Florida, but again no monies were appropriated. Another study headed by Dr. Lippard resulted in appropriate recommendations toward financing the building of the medical school. By 1951 the legislature had appropriated monies for assisting the first medical school in Florida at the University of Miami. A year later, in July 1952, Dr. Russell S. Poor was selected as director of a medical center study and, with a committee consisting of 15 Florida practitioners of medicine, outlined the status of Florida physicians in the 1950's, described the health needs of the people of Florida, discussed Florida's hospitals and nurses and provided a resume of the university programs related to medical education.

In April 1953, the legislature appropriated $5 million for the building of a medical sciences building, to house colleges of medicine and nursing on the campus of the University of Florida with the recommendation that the already functioning College of Pharmacy and Cancer Research Laboratory be integrated into this unit at a later time. Dr. Russell S. Poor was selected as provost for the Health Center, and Dr. George T. Harrell, who had also been on the committee for the Health Center study, was selected as the first Dean of the College of Medicine.

In late fall 1954, the actual construction of the Medical Sciences Building was begun. A year later, in April 1955, the legislature approved $8.6 million for construction of the teaching hospital which was to join the Medical Sciences Building, thereby insuring the establishment of the second phase of the development of the Medical Center.

The Medical Sciences Building was completed in the fall of 1956, barely in time for the first medical class of 48 students. The cost of the 238,000 square foot building was $5.4 million. A group of key department chairmen was selected and the school began its active education of phy-

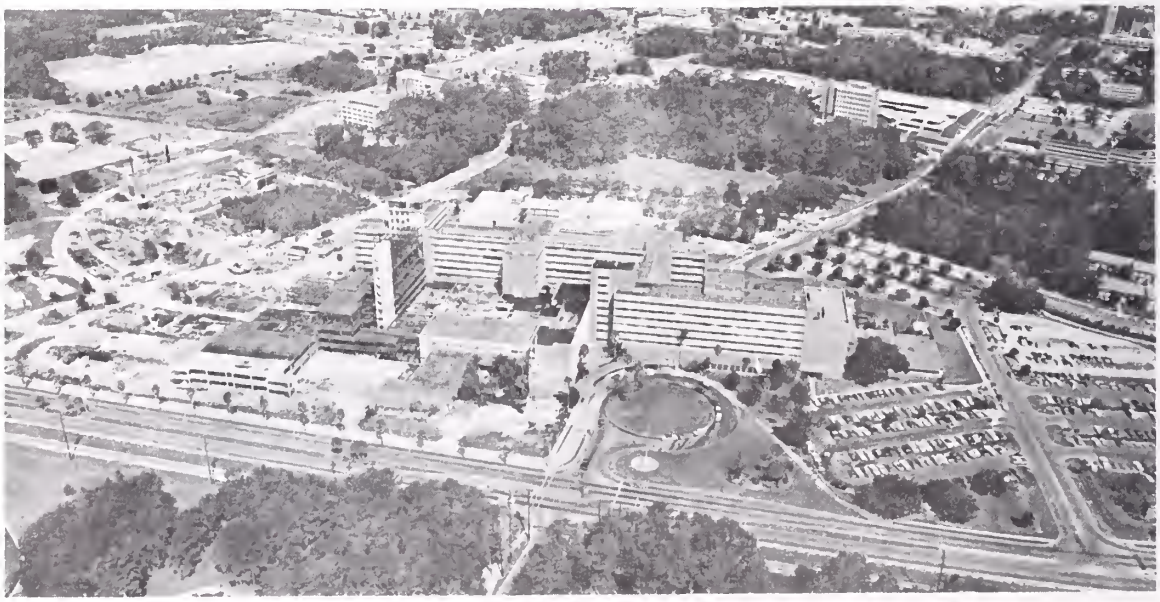
Dr. Stetson is Dean and Professor of Pathology, University of Florida College of Medicine, Gainesville.

sicians for the state of Florida. In October 1958 the teaching hospital was completed and opened at a total cost of $9.8 million for its 375,000 square feet. The teaching hospital, the clinics and ambulant wing consisted of seven floors with a connecting section between the hospital and the Medical Sciences Building. By 1959, the Florida legislature had appropriated $1.4 million which, together with matching federal funds, provided for construction of a pharmacy wing on the western end of the Medical Sciences Building, thus allowing the College of Pharmacy to be integrated with the Medical Sciences Building and combining under one roof the Colleges of Medicine, Nursing, Health Related Professions and Pharmacy.

Thus from the time that clear need was demonstrated for a medical school in Florida as indicated by the Florida legislature action in 1943, there was a 13-year delay before this school was completed and a 17-year delay before the first medical class was graduated. It is important to note that the major part of the plan for the Health Center in the early stages at least was by nonmedical people. Careful emphasis on preplanning and study of the problems involved in the setting of realistic goals made for a much smoother development program in later years while studied selection of key personnel and initial chairmanship appointments undoubtedly influenced the rapid procurement of faculty which followed.

The College of Medicine was fully accredited by the American Medical Association and the Association of American Medical Colleges in the spring of 1960, and on June 6, 1960, the College graduated its first class of 40 students. The stage was now set for a period of rapid growth and development. Under Dr. Harrell's leadership, the faculty grew in stature and in numbers, and both private and public funds were provided in abundance to assist the young school in developing its educational, patient-care and research programs. In 1962 the Clinical Research Center was established with a grant of over $2 million from the National Institutes of Health, and the Eye Clinic was opened as a valuable new clinical and teaching resource for the state. Dr. Poor resigned his position as Provost to become Director of Nuclear Education and Training with the Atomic Energy Commission in 1962, and was replaced by Dr. Samuel P. Martin. In 1964 Dr. Harrell resigned as Dean to preside over the creation of another new school of medicine in Hershey, Pennsylvania and Dr. Emanuel Suter was selected as the School's second dean. In August, 1965 a federal grant was awarded to support the new Center for Neurobiological Sciences which has come to be a major strength in the teaching and research programs of the College. Also in 1965, construction was started on the Human Development Center and the Child Psychiatry Unit, supported by funds appropriated by the state legislature and matched by a grant from the Health Research Facilities Branch of the National Institutes of Health.

A major development in the life of the College of Medicine was the founding of the Veteran's Administration Hospital just across Archer Road.



University of Florida College of Medicine

Mr. J. Malcom Randall was appointed director in 1966, and the hospital was activated in 1967. This 480-bed hospital has been, since its inception, closely affiliated with the College and the relationship has been a model of cooperative endeavor. Teaching programs of the College of Medicine have been much strengthened by this resource, while patient care at the Veteran's Administration Hospital has been superb because of the participation of College faculty. The year 1967 also saw the development of a close relationship between the College of Medicine and JHEP (Jacksonville Hospitals Educational Program). This relationship was formalized in 1969 by an action of the Board of Regents which in effect made JHEP a division of the J. Hillis Miller Health Center. Under this agreement the University of Florida is responsible for graduate medical education and for continuing medical education programs in the participating hospitals in Jacksonville, an arrangement which greatly benefits both parties and strengthens their programs. In the same year, the library of the Health Center became a participant in the MEDLARS program of the National Library of Medicine, thus acquiring access to a computerized information retrieval system of value to students and teachers alike.

During the 1960's much emphasis was placed on the development of maternal and infant care programs in the Department of Obstetrics and Gynecology. In 1966 the Florida State Board of Health made a grant to the Department for a Maternal and Newborn Care project aimed at providing prenatal and postnatal care to mothers and newborns in rural areas of 13 north Florida counties. This and related programs attracted national recognition and provided a strong base for the obstetrical and pediatric teaching programs of the College. In 1967 Mrs. Cordelia Seaife May made a gift of $600,000 to establish the first endowed chair in the history of the University of Florida and this chair was named for former President J. Wayne Reitz. Subsequently two additional endowed chairs have been created in this department to support work in the general areas of developmental and reproductive biology and of family planning.

Another change in leadership occurred in 1967. Dr. Samuel P. Martin stepped down as Provost of the Health Center and was replaced, in 1969, by Dr. Edmund F. Ackell. At about the same time the Board of Regents had approved a $30 million building expansion program and Dr. Ackell shepherded this largest of all University of Florida projects through difficult times to its present happy fruition. Nearly $20 million in federal funding was secured, remaining funds were allocated by the state in 1969, and bids were opened in January 1971. Unexpectedly high construction costs forced some cutbacks in the project, but groundbreaking took place in May 1971 and the first elements of the project are being finished as this is being written. The finished project will have nearly doubled the space available in the Health Center; will have provided full teaching, research and clinical facilities for the new College of Dentistry; will have provided unmatched study and teaching facilities for students of the College of Medicine, and will have provided for necessary expansion of the library and of other elements of the Health Center including the College of Nursing and the College of Health Related Professions.

Another milestone in the development of the College of Medicine was creation of the Department of Community Health and Family Medicine. Begun in 1968 as a division within the Department of Medicine, the new unit was dedicated to the training of family physicians and quickly received enthusiastic acceptance and support. It acquired departmental status by Board of Regents action in 1971 and has many achievements to its credit in its short life: development of a model rural health clinic in the town of Mayo where 1,000 citizens and 2,000 rural neighbors had been without a doctor for ten years; development of the state's first physician's assistant training program in cooperation with Santa Fe Community College; and establishment this past year of three model family practice residency programs in Gainesville, Tallahassee and Jacksonville. Also begun in 1968 was an imaginative and effective program under which electrocardiograms are telephoned in to the Health Center from communities throughout north Florida and immediately processed and interpreted by computer. Checked by experienced cardiologists, this service continues to be of real benefit to physicians and patients alike, and represents a particularly successful effort on the part of the College of Medicine to serve as a resource for physicians throughout the state.

The year 1969 saw the inauguration by students of the annual Hippocratic Award for Teaching Excellence which has already become a traditional spring event; commencement of an in-service continuing education program for Florida physicians; and the opening of the Tumor Biology

Laboratory which has already gained an international reputation for research in the field of tumor immunology and tumor viruses. Shortly thereafter, a three-year planning effort resulted in the opening of the Pediatric Intensive Care Unit to give the sophisticated care demanded by rapid advances in pediatrics and surgery. The state's first live kidney transplant was performed here in 1970, and an active renal transplantation program has been developing ever since together with a renal dialysis program.

Pursuing its objectives of cooperating with community groups for furthering graduate medical education, the College entered in 1970 into a academic affiliation with PEP (Pensacola Educational Program) providing for strengthening the house staff and continuing education programs of several hospitals in that city. At about the same time, the College entered into an arrangement with Florida State University and with Florida A & M University, under which students at the latter universities enroll in the Program in Medical Science (PIMS) at Tallahassee, receiving most of their preclinical medical education prior to graduation from college. This enables those students to enter the College of Medicine at the University of Florida with advanced standing, with an opportunity to obtain the M.D. degree seven or even six years after leaving high school. The first students from PIMS arrived at the College of Medicine in September 1972 and are doing nicely. Fifteen more students from that program joined our students this fall, and 30 more are scheduled to arrive in the fall of 1974. The graduating classes from this College of Medicine, which have averaged about 60 students each, will now increase in size due partly to the students transferring from PIMS and partly to an increased number of students being admitted to our first year classes. It is expected that by 1977 or 1978 between 140 and 150 students per class will be graduating.

From its inception the College of Medicine was designed to be part of an academic health center, rather than a free-standing medical school. Master planning provided for housing all components of the Health Center under a single roof, facilitating interaction between the staffs and students of the several colleges. The College of Nursing was begun in 1956; College of Health Related Services was founded in 1958 and renamed the College of Health Related Professions in 1964; College of Dentistry admitted its first class in 1972; and the College of Veterinary Medicine is still in its planning stages. The College of Pharmacy moved into the Health Center in 1961. These Colleges together with the Shands Teaching Hospital and Clinics make up the J. Hillis Miller Health Center, which has served as a model for the development of academic health centers around the nation. Students in all these colleges are "learning together to work together" in the health team concept, an idea which has survived all the difficulties inherent in the stepwise and sequential development of the units.

The objectives of the College of Medicine continue to be (a) to furnish the best possible medical education to each of our students whatever his or her career goals may be; (b) to help in providing for the people of this state a unique and sophisticated referral center with diagnostic and treatment facilities beyond those which can be supported in community hospitals; (c) to cooperate with the Florida Medical Association, county medical societies and community physicians in providing various modalities of graduate and continuing medical education for Florida's physicians, and (d) to conduct research programs which range from basic research to studies of health care delivery systems. Emphasis in recent years has been on trying to help solve Florida's needs for more medical manpower in the area of primary care and family practice, through changes in undergraduate curriculum and development of family practice residencies and rural health care programs. A recent curriculum reorganization has provided for an integrated basic science teaching program and for more elective time to permit each student to have in-depth experience in areas of his own choice. The youth and relatively small size of the College have been positive factors in attracting able students and teachers alike, since there has been ample opportunity for close student-teacher relationships. The College has been blessed from its beginning with able leadership and with the far-sighted support of countless dedicated and public-spirited citizens. With all the uncertainties in these troubled times for medicine and medical education, the College looks forward with good hopes and clear prospects of fulfilling its destiny as a premiere institution of the state and the region.

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▶ Dr. Stetson, University of Florida College of Medicine, Gainesville 32601.

University of South Florida College of Medicine

Donn L. Smith, M.D.

The Florida state legislature provided the charter for the state's newest College of Medicine in 1965. Organized medicine in the Tampa Bay area played a major role in the successful drive to obtain legislative authorization for the creation of the new School of Medicine to be located in Tampa.

In October 1969, after considerable initial study and planning, the first full-time Dean and Director of the Medical Center was appointed and the College office was opened January 1, 1970. In September 1971 the charter class was admitted and began the academic program of study. Between 1970 and 1971 the Basic Science faculty was recruited and housed in temporary quarters in the University of South Florida Science Center.

During the period 1970-1972 a $26 million medical center physical facility was planned and designed. Construction began in April 1972 with a completion date for the entire program scheduled for August 1975. The first phase of construction, student and faculty laboratories, classrooms and the medical library, will be completed in July 1974. The buildings are designed to facilitate teaching, research and ambulatory patient care. The final phase, now under construction, will provide facilities for clinical science ambulatory care, an auditorium and a College of Nursing. Generous financial support from the State University System, Florida legislature and federal government has made the construction program possible.

Inasmuch as the College of Medicine will conduct clinical instruction in a group of community hospitals, no university hospital was planned. The initial affiliates are Tampa General Hospital, Tampa Veterans Administration Hospital, and St. Joseph's Hospital, all in Tampa. In addition, affiliation has been arranged with All Children's Hospital and the Bayfront Medical Center, both in St. Petersburg. Additional community hospital affiliations will be arranged in the central Florida and Gulf Coast areas as the Medical Center grows.

A distinguished medical faculty has been recruited to date and the full faculty and staff complement will be in place by 1976.

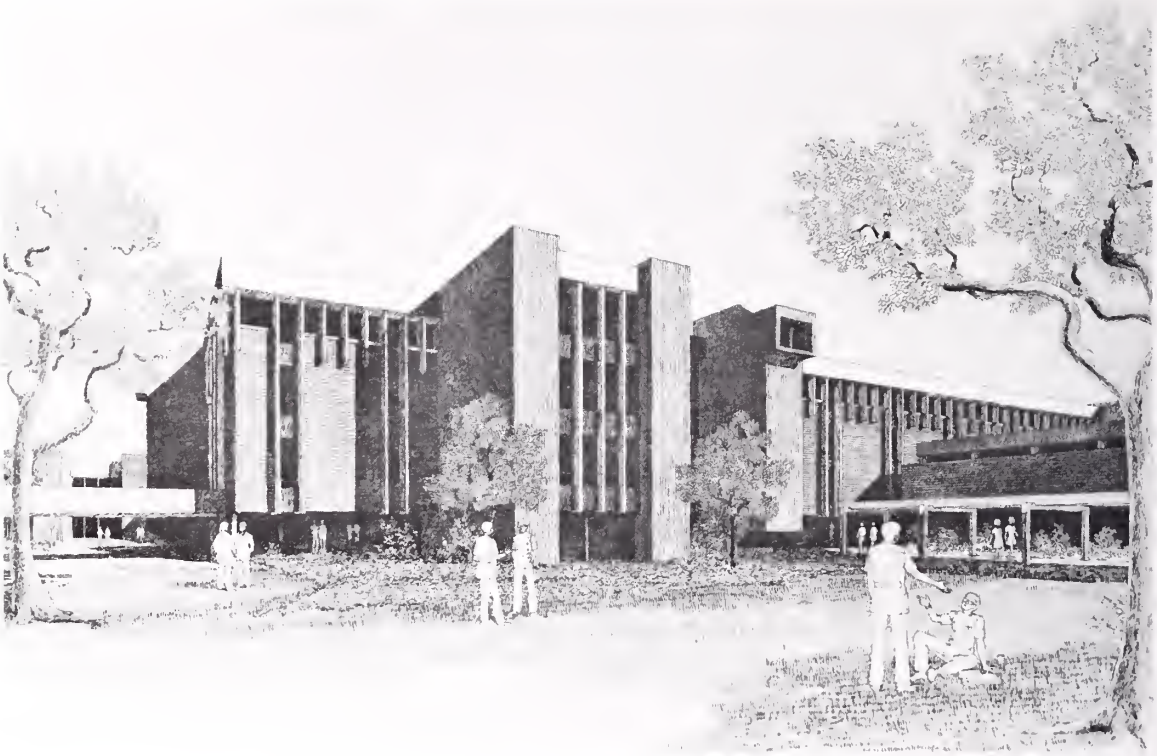
The charter class, admitted in September 1971, consisted of 24 students selected from over 400 Florida residents. The second and third classes began their studies in July 1972 and July 1973. The curriculum is designed to allow students to complete the work leading to the M.D. degree in 36 calendar months by virtue of year around attendance. This program allows each graduate an additional year of medical practice during his or her career as a physician.

As a new institution, the College of Medicine is characterized by constant and continuing growth and development. New programs are instituted at frequent intervals. A neonatal intensive care unit has been established and is furnishing excellent support for pediatricians in central Florida. The renal transplant program is underway as well as acute and chronic renal dialysis facilities. A Lions Club sponsored eye bank has been placed in operation. An excellent and very functional medical library is being created to serve the Medical Center and the physicians of central Florida. Recently an endowed chair in cardiology has been awarded to the College of Medicine by the Suncoast Heart Association.

Residency training programs have been established in all of the appropriate medical specialty areas. The house staff training programs are sharing in the rapid growth of the institution, with students in graduate medical education coming to Tampa from across the nation. Included is a well-developed family practice residency at the Bayfront Medical Center in St. Petersburg.

Legislative and community support has been excellent and large numbers of the medical profession as well as lay citizens have contributed in a significant way to development of the Medical Center. In the presence of rapid growth, care is

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.



University of South Florida College of Medicine

being taken to provide the requisite sound base for the ultimate emergence of a truly distinguished College of Medicine oriented towards excellence in teaching and patient care. Research and community service will also represent an important segment of the goals of the College.

The goals and objectives have been defined and are stated as follows:

1. To provide conceptually oriented teaching which will afford the student a challenging intellectual experience rather than the routine and superficial large volume of fact presentation.

2. To encourage close student-faculty relationships so that the students will regard the faculty not as teachers of didactic information, but rather as guides to learning.

3. To achieve a visible and effective correlation between the preclinical and clinical instruction.

4. To increase the correlation on an interdisciplinary basis so that adequate reinforcement may occur between the various fields of study, especially the preclinical and clinical courses.

5. To provide a close and ongoing experience for the student in the day-to-day and continuing health care delivery system within community hospitals and in ambulatory care facilities, thus to produce graduating physicians who understand and desire the practice of medicine as a fruitful and meaningful choice for a lifetime career of service to their patients and community.

Although our history and therefore this written exposition are brief, the future holds great promise. Implementation of the full potential of the University of South Florida Medical Center will provide a great educational and health care asset for the people of Florida.

▶ Dr. Smith, College of Medicine, University of South Florida, Tampa 33620.

Notations on Pensacola's Medical History 1873-1923

Elizabeth Dwyer Vickers and F. Norman Vickers, M.D.

1873-1882

At the end of the Civil War, Pensacola, a Gulf coast city whose heritage dates back to 1559, was devastated. A returning son described the dismal sight in a letter. "Everywhere the eye turns it rests on demolished buildings, and destroyed shrubbery, and as you pass along the streets, you must thread your way through milk weeds and hog grass."[1]

The postwar recovery of Pensacola proceeded at a painfully slow pace. In 1874 William Henry Davison, a civil engineer, wrote in his diary "the year ends on a state of extreme impecuniosity and no prospect of anything better for a year at least. I suppose by the next year we shall all be in our graves, starved to death!"[2]

Despite such pessimistic reflections, Mr. Davison, and possibly many other Pensacolians found solace in the magnificent beauty of the surrounding piney woods. How prophetic that the diary entries reflecting the few notes of optimism should involve the "piney woods." It was these beautiful, naturally landscaped forests that afforded Pensacola its golden age of affluence in the latter part of the 19th century.

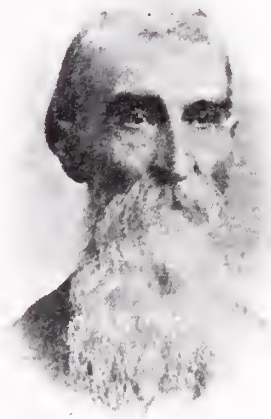
In 1870, Pensacola had a population of about 3,750; by 1880 it had increased to 6,700.[3] The decade witnessed only minor improvement in its physical appearance. Its seven miles of streets were unpaved, sewers and waterworks were nonexistent and oil lamps illuminated the dusty, sandy thoroughfares.[4]

From its inception Pensacola's growth and progress were often jeopardized by various forces —hurricanes, fires and ravaging epidemics. The character of the city was shaped by the capabilities of the inhabitants to cope with these adversities.

Yellow Fever

From 1873 to 1883 yellow fever was probably the most significant factor that challenged Pensacola's endurance. An illness that had invaded the city in epidemic form many times during the 19th century, it precipitated chaotic fear among the townspeople, divided the community leaders regarding appropriate courses of action, paralyzed the economy and claimed many lives.

Theories regarding the origin of yellow fever sparked many controversies in the medical profession. Pensacola physician, Dr. Robert Bell Smith Hargis was a strong advocate of the ship origin of yellow fever. He subscribed to the concept that the foul musty holds of ships provided the precipitating conditions in the development of the disease. Over a 30-year period he relentlessly devoted his literary talents to the defense of his theory. In summarizing the data on the devastating epidemic of 1882 in Pensacola, he directed strong criticism against the Italian ships. "The seamen are ill-fed, ill-paid, and always dirty; such a vessel can never be safe in the calm belts from pestiferous emanations; and I am utterly astounded when I enter such a vessel, reeking with numerous conflicting odors [sic] of the most poisonous and nauseous type that any human being can doubt the pernicious tendency of such conditions . . . With a free surface to air, a marsh develops malarial poison. How much more deadly, . . . will this fouling of holds, deprived of oxygen so that lights go out in the well and elsewhere, induce a malady unlike anything else we know of except in the mountain of records of Atlantic traffic and Atlantic ports."[5]



Robert B. S. Hargis, M.D.

Dr. Hargis was confident of the validity of his ideas regarding yellow fever. As a young practitioner in Pensacola in 1853, he had contracted the illness. His medical practice from then until his death in 1893 included caring for Pensacolians during several yellow fever epidemics.

In 1867 when yellow fever appeared in the area, about 90 people died. Dr. Hargis and other generous townspeople rented a two story building at the corner of Palafox and Romana Streets and converted it into a hospital. Many of the ill were mariners with no homes in the area. Pensacolians joined Dr. Hargis and other physicians in caring for those hospitalized as well as those ill in private homes. Interestingly, there are no epic reports of a mass exodus of frightened people to "safe" areas. The zealous Samaritans exhibited no fear in this charitable venture of providing food and nursing care and burying the dead.[6]

Dr. James S. Herron supported Dr. Hargis' ship theory when he wrote his report on the Pensacola yellow fever epidemic in 1874.[7] The Spanish bark, Virtuoso, arrived in Pensacola in late May. Two crewmen had died of yellow fever en route from Havana, a third died after arrival. In July another infected vessel arrived and subsequently the majority of her crew died. In accordance with quarantine regulations, the infected ships were retained at the quarantine station, located at Live Oak Plantation (Live Oak Reservation included the entire peninsula and is the present site of the city of Gulf Breeze) for fumigation and isolation. If properly implemented, the quarantine regulations should have been sufficient to protect Pensacola and the nearby Navy Yard from the spread of the disease; however, slack enforcement enabled sailors and stevedores to travel back and forth to town regularly, and eventually both areas were disastrously affected. Pensacola had about 354 deaths (population 3,347) and the Navy Yard about 17. Among the latter deaths were two Navy surgeons, J. B. Ackley and G. B. Todd.[8] Understandably, the report of the Navy investigation was harsh. "The quarantine established by the City of Pensacola against the infected shipping was rather worse than useless, because enacted under the very crudest imaginable notions as to what a quarantine should be."[9]

Disregard of port quarantine regulations apparently contributed to an epidemic of yellow fever in 1875, this time at Barrancas. The Von Moltke arrived in port with five cases of yellow fever aboard. According to Dr. James Herron, it, ". . . anchored, during the night, a short distance inside the bar, between Fort Pickens and Barrancas. The Pilot, Roach, landed to visit his home in Warrington, . . . and remained there all night; . . . but reboarded the Von Moltke the next morning, and, after taking her up to the quarantine station, returned again to Warrington, where, a few hours after, he was arrested and sent, under guard, to quarantine."[10]

The military enforcement of quarantine was effective in confining the disease to the reservation. Despite 76 cases and 31 deaths at Barrancas, Pensacola was gratefully spared. This fortunate situation enabled Dr. Herron to spend a month at Barrancas to render medical care since the surgeon in charge, Dr. George Miller Sternberg, was one of the 76 cases.

The aura of mystery which shrouded yellow fever seemed to extend to the concept of quarantine and its implementation in Pensacola in the 1870's. In essence the regulations stated that the city mayor was to proclaim the period of quarantine each season—usually from May to November or about the time of the first frost. All ships had to stop at the Live Oak Plantation quarantine station. The quarantine physician appointed by the City Council boarded and inspected all ships. Ships coming from infected ports were fumigated and the crew and passengers detained in isolation for 21 days. Any yellow fever cases were admitted to the hospital at the station. Designed to "secure and preserve public health"[11] these ordinances were vulnerable to the political manipulations of the times.

Davison's Diary

William Davison had opportunity to observe the weaknesses of the quarantine system when he worked as a port inspector at the quarantine station during the summer of 1876. An astute person, his educational experience had included studying under Longfellow while at Harvard College. Married to a Pensacola girl, he had lived in the south many years. To divert his attention from the frustrations of isolation at the quarantine station, he studied Spanish and wrote in his diary.

Inconsistencies abounded in quarantine enforcement. Perhaps even the Board of Health and the elected officials who authored the quarantine regulations doubted their necessity and effectiveness. Regulations stipulated that vessels from clean ports could proceed to Pensacola after the quarantine physician inspected them and declared them free of illness. However, in late summer of 1876 the ordinance was revised; all vessels had to

discharge ballast at the quarantine station and be fumigated. Such a rigid ordinance seemed illogical when Mr. Davison and Dr. Theobold M. Leonard were confronted with a shipload of fine quality salt and another of bananas! The mayor was relentless; the ship, May Morn, was fumigated and sailed into Pensacola with a cargo of salt smelling of sulphur. The bananas fared better; they were rescued from the process by the influence of Ned Dunn, a stevedore and ballast contractor who had great influence with Mayor Jones. One of the stevedores, a Mr. Dunford, was also a member of the Board of Health. It is interesting to note that Mr. Davison cites him as one who would go to the outer buoy to meet ships and secure the loading contract. Apparently no forces were available to arrest this highly-placed quarantine violator! "This action of one who should be a guardian of the public health, in effect breaks up quarantine, as far as it is of any use to protect the public health, for the other stevedores all declare that they will board all ships outside now, when they please. Of course this violation of the quarantine has been reported to the Mayor, as other cases have been before, and, as in all those cases, the violations of the law will go unpunished. So much for having a weathercock at the head of affairs."[2]

Yellow Fever in 1882

In 1882 the city was again attacked by yellow fever. On the basis of previous condemnations, physicians were reluctant to publicize the first diagnosis without more substantiating evidence. Dr. Hargis wrote:

"I took good care at the earliest moment to influence all I could to depart; but no, the tendency was to prolong quarantine . . . I ordered the first vessel recognized infected [Spanish Bark Saleta] to leave for quarantine without post-mortem examination, least [sic] I should arouse the fears of the whole town. . . . The ship I ordered to quarantine dreaded detention, and sailed for Havana, losing two of her crew on her brief passage.

"The more prominent the position of a yellow fever physician in local sanitary councils, the more guarded must be his words, until the evidence, pure and simple, of an undoubted case presents itself, as that of Mrs. Cobb, who died on the 28th of August of hemorrhage and black vomit. My friends acted on my profound belief, and the untutored, still resting their fancies on local origin, denounced me in unmeasured terms."[5]

The first suspected case of yellow fever had been seen on August 9 by Dr. Herron and Dr. Hargis, President of the Board of Health. By mid-August, it had spread to Warrington, Woolsey and the Navy Yard and caused 33 deaths. By mid-October the epidemic subsided; it had claimed over 190 lives.

It requires no great exercise of imagination to envision the emotional atmosphere that prevailed in Pensacola during this epidemic. Rumors circulated regarding the true nature of the illness in town. Physicians were hesitant to commit themselves. As Dr. Hargis had commented in 1873, ". . . I had the temerity to exercise the melancholy duty of reporting to the Board of Health the first case. For this, I was denounced by a private citizen, and called 'a d—d old fool, incapable of performing the duties of his profession'."[12]

Barrels of sulphur and tar were burned nightly in streets and alleys to destroy those mysterious atmospheric conditions "which favor the reproduction and dissemination of the morbific principle."[5] Quarantine regulations prevented anyone from entering or leaving the city. Pensacolians were impounded by their own decree.

Between 1876 and 1882 the quarantine system evidently experienced no significant improvements. Shipping interests felt they were being victimized and blatantly violated the regulations. Dr. Alfred M. Owen, U. S. Navy Surgeon, commented that the quarantine officially started on May 15, 1882 but effectively began in late June. The Navy ship Canonicus moored between Deer Point (Live Oak Reservation) and Little Sabine, site of the quarantine station which had been moved to Santa Rosa Island on April 10, 1882. The crew of that ship reported that, "the regulations were not being observed and that the quarantine was a farce. Sailor runners and boarding-house keepers, ship-chandlers and stevedores were allowed to come and go at all times . . ."[13] They further reported that the quarantine physician lived at home with his family on the mainland until mid-July!

In marked contrast, the Navy posted a picket line of acclimated workmen. It extended four and three quarters miles around the military reservation. Boats were removed from Bayou Grande; incoming mail from Pensacola was fumigated and a steam launch patrolled the beach.[13]

Pensacola Medical Society Founded

In this turbulent decade (1873-1882) the Pensacola Medical Society (the original name of

the Escambia County Medical Society) was organized. The details of the Society's charter, membership, objectives and accomplishments have been obscured by the passage of more than a century. It is conceivable that these records were destroyed in the December, 1880 fire that swept down Palafox from Romana Street to Main Street.[4] However, several publications seem to agree that the Society was founded in 1873.[14-16]

On the basis of speculation, one can deduce two possible reasons why the physicians of Pensacola formed a medical society in 1873—the menace of yellow fever and the need for a forum for exchange of medical knowledge.

Yellow fever was a major public health problem in Pensacola in 1873. The local Board of Health controlled by its lay membership frequently disagreed with the medical members regarding prudent courses of action when epidemics threatened. There was a great need for strong unity among the physicians of the area in order to become an influential force in coping with the health of the city. A medical society would provide a logical organizational vehicle.

It is interesting to note that in 1875 Dr. Herron consulted the "Medical Society and the Board of Health of Pensacola, as to the propriety of my return after constant contact with the disease."[10] He had rendered medical care at Barrancas for one month during the epidemic there.

The Pensacola physicians were geographically isolated from large cities and universities; however, it appears that this was no deterrent to their pursuit of medical knowledge. Dr. Hargis' voluminous published writings of that era are suggestive of an inquiring mind. Surely, Dr. Hargis, the first President of the Society,[14] would influence the organization to become a forum for the exchange of ideas and professional knowledge.

The interests of the young medical society soon expanded to include the Florida Medical Association. In 1878 Drs. Hargis and Herron attended the annual meeting in Jacksonville and became members. Dr. Hargis presented a report to the chairman of the Committee on Endemic Diseases in which "he contended for the Importation Theory."[17] In 1880 he was elected First Vice President of the state organization.[18] In April 1882 the FMA convened at Washington Hall (Palafox Street, opposite the Public Square). Dr. Hargis gave the annual oration, "The Genius of Medicine," and was elected President and Dr. T. M. Leonard was elected Secretary.[19]

Dr. R. B. S. Hargis

The founder of the Pensacola Medical Society, Dr. Robert B. S. Hargis, must have been a charismatic person as evidenced by his accomplishments during his 40 years in Pensacola.

He was born in Hillsborough, North Carolina on June 7, 1818. He studied at the University of North Carolina and served a preceptorship under Dr. T. J. Jordan of Fayetteville, North Carolina. He was graduated from the Medical College of Louisiana (now Tulane) in 1844. In 1851, following several years of medical practice in Alabama, he came to Pensacola and was appointed Port physician in 1852. A yellow fever sufferer himself in 1853, he spent a convalescent year in Milton, Florida. He was appointed Surgeon to the U. S. Marine Hospital when he returned to Pensacola in 1854.[20] The Marine Hospital was located in a rented three-story house on Pensacola Bay about one mile east of the city.[21]

Dr. Hargis founded the earliest known proprietary hospital in Pensacola in 1854. The facility, contiguous to the U. S. Marine Hospital, has been variously known as the Pensacola Infirmary and the Pensacola Hospital. Newspaper advertisements indicate the fees for care at the Infirmary varied from $2 to $2.50 per day. Charges for surgical operations were extra.[22] When the U. S. Marine Hospital burned in November 1854, the federal government contracted for care of marine patients at the Pensacola Infirmary.[23]

Dr. Hargis served in the Confederate Army during the Civil War. After the war he returned to practice in Pensacola and in 1868 he and Dr. J. C. Whiting established the Pensacola Hospital. Presumably, this was a reopening of his prewar facility.[20] His concern about yellow fever and its disastrous consequences prompted a strong interest in the cause, prevention and treatment of this disease and the publication of many scientific papers on the subject. "Communicability of Yellow Fever" was published in The New Orleans Medical News and Hospital Gazette in 1859.[20] "History and Origin of Yellow Fever—Its Cause, Communicability and Prevention"[20] was read before the American Public Health Association in 1879 and subsequently published in Report and Papers of the American Public Health Association in 1880. He dissertated on his unswaying belief that the disease emanated from the filthy holds of ships with a trio of papers in 1880—"The Nautical Origin of Yellow-Fever" in Letters to the Sanitarian, New York; "The Ship—Origin of Yellow-

Fever," Gaillard's Journal for June 1880; and "Yellow-Fever—Its Ship Origin and Prevention," published by a Philadelphia physician, Dr. D. G. Brinton in 1880.[20] His "Sketch of the History of Quarantine" at Pensacola, Florida in the August 27, 1881 edition of the National Board of Health Bulletin[21] is a fascinating commentary on Pensacola's early efforts to cope with yellow fever.

Dr. Hargis' literary endeavors regarding yellow fever were paralleled by his efforts in the field of public health. In 1878 he became a member of the American Public Health Association. In 1881 he was appointed to the Board of Health of Escambia County and served for two years. This two year assignment was a painfully challenging one; yellow fever invaded the area in 1882 and in 1883. At the request of the National Board of Health Dr. Hargis conducted an investigation of the 1882 epidemic with Dr. William Martin of the U. S. Navy.[20]

Dr. Hargis was married to Miss Modeste Sierra, a granddaughter of Dr. Eugenio Sierra, who had come to Pensacola in 1781. The Hargises maintained a home on Romana Street, the present site of the Pensacola News Journal Building.[24] Two of Dr. Hargis' children, Robert W. and J. Whiting, became prominent local physicians. Dr. Hargis died in 1893.[25]

Dr. James S. Herron

Another prominent charter member of the Pensacola Medical Society was Dr. James S. Herron. His father, James, was a highly respected civil engineer at the Navy Yard. Dr. Herron studied at Springhill College and received his medical degree from the University of Pennsylvania in 1861. After serving as a surgeon in the Confederate Army, he returned to Pensacola to practice.[14] In 1874 he purchased the Innerarity House on the old Panton Leslie Trading Post and converted it into a Marine Hospital. To accommodate his patients, primarily seamen, he built a tunnel from the hospital to the beach.[26,27] Dr. Herron built a handsome home on North Palafox Street (present site of the Knights of Columbus Hall) and died there in 1915.[28]

Other physicians who practiced in Pensacola during this era were William Francis Fordham, Alabama Medical College, 1875; Robert C. White, University of Louisville, 1853; Edmond Bouvier; T. M. Leonard, J. C. Whiting and Frank Gale Renshaw, Medical College of Louisiana, 1880.[29]

1883-1892

Pensacola experienced one of her most colorful periods of growth from 1883 to 1892. During this golden era, the city was transformed into a bustling, enterprising Gulf port. Six hundred vessels cleared the port in 1885;[3] at times the Bay was literally a "forest of ships."

The virgin forest of northwest Florida was the source of enticement. ". . . yellow pitch pine which grew so thickly in some places that it was difficult for a horse to ride through, was to bring riches to a variety of people from all over the globe. Italians, Spaniards, Scandinavians, Germans . . . all came seeking wealth."[3]

The city grew from a modest population of 6,700 in 1880[3] to 10,536 in 1885.[30] Palafox Street was paved north to Garden Street. The Pensacola Waterworks was started. Three railroads facilitated transportation and a public school system was established.[4] The construction of impressively designed homes further reflected the prevailing affluence.

Yellow Fever at Rand's Boarding House

The waterfront area, built up with ballast from the ships, was the site of many boarding houses catering to seamen. Money was easy and a natural attraction for gamblers and prostitutes. Barroom brawls and killings occurred frequently.

One of the most controversial yellow fever incidents in Pensacola public health history originated in one of these waterfront boarding houses in August 1883. It precipitated an unparalleled degree of fear, suspicion and hostility among Pensacolians.

The volatile situation originated on August 22 when Dr. Robert C. White was called to examine two ailing seamen at Rand's Boarding House. His diagnosis of yellow fever was supported by Dr. Jerome Cochran, a visiting Alabama physician. Dr. Cochran, a Montgomery (Ala.) Board of Health official, was in the area to assess reports of yellow fever at the Navy Yard.

The Pensacola Board of Health concurred with the diagnosis and the two patients were promptly transferred to the quarantine station. Dr. Cochran noted that, ". . . the shanty (Rand's) in which they had been housed was pulled down and burned in the presence of many hundreds of excited citizens. The excitement spread rapidly over the city, and that night there was a general exodus of all unacclimated persons who could get away."[31]

One of the affected seamen died the following day at the quarantine station. The Marine Hospital Surgeon, Dr. Robert Drake Murray, performed an autopsy and attributed the cause of death to "swamp fever, pernicious or congestive malarial fever" and not yellow fever.

Drs. James S. Herron, Frank Gale Renshaw and J. Z. Cravey, three local physicians with extensive experience in previous yellow fever epidemics, expressed strong disagreement with Dr. Murray. A signed statement by them supported the original position of the Board of Health physicians, R. C. White and William Francis Fordham. They maintained that a postmortem examination was not conclusive evidence in diagnosing yellow fever.

Evidently Pensacola had greater respect for Dr. Murray's judgment. His assessment of the situation was accepted and the city returned to normal. Dr. Warren E. Anderson of Millview recalled that, "They (Board of Health) now sought to atone for injuries inflicted on the commerce of Pensacola, and to allay the just fears and suspicions of their neighbors by declaring the nonexistence of any fever in the city, and stating that the general health of the community was never better—consequently, the alarm and excitement caused previously was extremely rash and uncalled for . . ."[32]

As a consequence of the official statement that no yellow fever existed, the quarantine restrictions against Pensacola by Mobile were lifted.

In view of subsequent events, it appears that the Board of Health's statement reflected the lay members' opinion only. Dr. Cochran submits no evidence that the physician members, Drs. R. C. White and W. F. Fordham, repudiated their original yellow fever diagnoses. He does indicate, however, that Pensacola physicians were pressured by a Mr. Guttman, Board President, to sign statements denying the presence of yellow fever in the city.[31]

In late September another yellow fever death occurred on Palafox Wharf. Rumors persisted that yellow fever was rampant in the city. "It was a notorious fact, and a matter of angry discussion and denunciation at the street corners, that the physicians had again and again asserted the presence of yellow fever in Pensacola; . . . in almost every issue of the Pensacola Commercial, there was served up for the delectation of the people some foul aspersion of the doctors, to the effect that dishonestly and mendaciously they had gotten up a yellow fever panic to the great injury of the city—said aspersion culminating finally in the sacrilegious petition, 'Send us a Frost, O! Lord, for the devil and the Doctors have conspired to ruin us!' "[31]

The rumors reached the ever-vigilant Dr. Cochran who returned to Pensacola in early October to determine the validity of the reports. Conversations with seven of the eight practicing physicians convinced him that yellow fever did exist in Pensacola. Appropriate action was taken by Alabama to reinstitute "quarantine" against Pensacola. The battle was on!

The Pensacola Commercial led the way in public denunciation of Dr. Cochran and local physicians. "To such men as Dr. Cochran, and some of our own doctors, the people are indebted for the loss of thousands of dollars of money, and an arrest of the progress and prosperity of this section that it may take years to overcome. Public slander has done its work, and the authors will yet receive the due reward of their nefarious conduct . . . We think it would be a good idea if every place that has any regard for its name for health would quarantine Dr. Cochran and not allow him to enter its limits during the season in which he could work up a panic."[31]

There were suggestions for removing the two physicians from the Board of Health so that "the wisdom of its counsels should not be marred by professional incompetency and mendacity."[31] There were even suggestions for hanging physicians in effigy!

The true proportions of the "epidemic" never emerged; however, the traumatic impact of the controversy was evidenced for many years by the city's strong regular need for reassurance that yellow fever did not exist in the area.

In July 1885 the Escambia County Board of Health responded to the circulating rumors that "suspicious cases of sickness" had occurred in Pensacola. A statement was issued to the effect that nothing more than a few cases of scarlatina and rheutmatism threatened the city's health. It included signed certificates from all the local physicians who strongly endorsed the health authorities judgment.[33]

An article in an August edition of The Pensacolian commented on the good health of the city and complimented health officials.[34] Perhaps the epitome of reassurance came from Dr. Jerome Cochran, the Alabama Public Health official who had evoked the wrath of Pensacolians with his

candor in 1883. He had occasion to redeem himself when he visited Pensacola in 1888 and pronounced it in good health![35]

Public Health

The responsibility of regulating public health in Pensacola in the 1880's was a challenging task of almost insurmountable proportions. The establishment of a Board of Health to implement this responsibility dates back to 1821 when Andrew Jackson assumed the governorship of Florida. Despite some legislative revisions over the years, the Board remained an essentially independent county agency whose membership was appointed by the Governor. What it lacked and desperately needed was a central body to coordinate its public activities with those of other boards of health in Florida. The Florida Constitution of 1885 had directed the legislature to establish a State Board and County Boards of Health. However, the legislature never passed implementing legislation to create and fund a State Board of Health. The main objective of the local Board was to protect the health of the people against the dangers of epidemics that had tormented Floridians for over a century; however, the wide spectrum of quarantine concepts prevailing in the state because of independent, locally controlled agencies resulted in much conflict and inefficiency.[14]

The fear of centralized power was a strong determinant of Pensacola's opposition to the 1889 proposal of Governor Fleming to provide for a State Board of Health. The Pensacolian commented that it was, ". . . impracticable and would render local Boards of Health utterly powerless, while such a State Board would be worse than useless."[36] The editor further warned that, " . . . it places autocratic and arbitrary power in the hands of one man and subjects the entire state, 400 miles wide by 500 miles long to the *ipse dixit* of the health officer . . ."[37]

Despite the dire prophetic warnings of The Pensacolian, the special legislative session of February 1889 approved Governor Fleming's proposal; a State Board of Health was established. William K. Hyer of Pensacola was appointed to serve on this Board which promptly began its work.[14]

The Escambia County Board of Health under the new law was comprised of J. W. Frater, William Fisher, D. G. Brent and Drs. Frank G. Renshaw and Robert W. Hargis.[38]

Despite the awkward framework within which the Board of Health had previously functioned and the constant suspicious scrutiny of the public, the Board applied the best knowledge available at the time. The quarantine station on Santa Rosa Island was regularly staffed each summer and all ships entering the port were inspected and fumigated.

One of Pensacola's sanitary accomplishments during this era merited praise from the new state health officer, Dr. Joseph Y. Porter. The completed four miles of the projected 16 mile sewerage system were ideal in design and recommended for other cities. Interestingly, he notes that Pensacola and Jacksonville were the only Florida cities with sewerage systems at that time (1890).[39]

Pensacola Physicians

Pensacola's medical community assumed new directions during this era with the arrival of several new private practitioners: Horace L. Simpson, College of Physicians and Surgeons, New York, 1886; William J. Hannah, Southern Medical College, Atlanta, 1882; Charles Franklin Marsh, University of Michigan, 1869; William Henry Ross, College of Physicians and Surgeons, New York, 1868; Charles Robert Oglesby, St. Louis Medical College, 1876; John Whiting Hargis, Kentucky School of Medicine, 1893; and Richard Waggener, Medical Department of Tulane, 1892. Perhaps the two who had the greatest impact on medical events at that time were Warren Edward Anderson, Medical College of Alabama, 1882, and Juriah Harris Pierpont, Medical College of Virginia, 1888.[40]

Dr. Warren E. Anderson

Dr. Anderson, a native of Marianna, Florida, began his practice in Millview, a small town on Perdido Bay about eight miles west of Pensacola. He was hastily oriented to the rigors of practice when yellow fever swept the town. In a letter to Dr. Jerome Cochran, he described the effects, ". . . we successfully combated the introduction of the fever during the epidemic of 1882 by means of a well regulated sanitary cordon, and the active enforcement of other stringent quarantine measures. However, we were not so fortunate the past season, and the foe entered from a loss on our part of that 'eternal vigilance' which is as much the price of health as it is said to be of liberty."[32] There were 70 cases of yellow fever among a population of 300. Dr. Anderson was one of the affected—an experience which enabled him to respond to Jacksonville's plea for acclimated physicians during the tragic epidemic there in 1888.[41]

Warren E. Anderson, M.D.

Juriah Harris Pierpont, M.D.

Dr. Anderson married Miss Catherine Hargis, daughter of Dr. R. B. S. Hargis, in 1889. Eleven children were born to them—nine boys and two girls. A daughter, Katherine, still lives in Pensacola. He died in February 1912.[41]

Dr. J. H. Pierpont

Dr. Pierpont was born in Savannah, Georgia, February 25, 1864. He recalled his educational background in his delightful memoirs, "Some Data on the Life of Juriah Harris Pierpont." "Attended a private school in Quitman, Georgia when 12 or 13 years old, a combination primary and grammar school. There were no public schools there at that time. My sister, 11 years my senior, taught me the three R's up to this time, and when I was about 18 arranged with a Baptist minister, who boarded with our family, to take me on for the high school subjects taught at that time. . . . At the age of 17, I became a telegraph operator, and secured a position with the Sanford, Florida Telegraph Company, where I worked about a year."[42]

Several months later while working in Bartow, he discovered a body that had been buried for a few years. Since no one in the area could identify the body, young Mr. Pierpont, an aspiring physician, claimed it for educational purposes. "I needed a skeleton very much at that time to aid me in the study of anatomy; so after the bones had been cleaned, I mounted the skeleton using an iron rod on which to string the vertabrae [sic]. Cigar boxes furnished the material for the intervertebral discs to give proper height."[42] He successfully completed his course in anatomy and physiology at the Medical College of Virginia. In March 1888 he graduated from that institution and was appointed an intern at the Richmond City Almshouse Hospital.

In 1894, Dr. Pierpont married Miss Lucy Warren of Pensacola. One of their four children, Mrs. M. M. (Florence) Marple continues to reside in the Pierpont family home and is a skilled raconteur of her father's various accomplishments.

Dr. W. C. Gorgas Arrives in Pensacola

The arrival of one physician who was destined to attain great prominence attracted virtually no attention. William Crawford Gorgas, an Army physician was stationed at Fort Barrancas from August 1888 to October 1892, and again from April 1894 to December 1897.[43] A graduate of the University of the South and Bellevue Medical College, New York City, (1875) he entered the Medical Department of the U.S. Army shortly thereafter. His medical accomplishments in the field of yellow fever sanitation in Cuba and Pan-

ama in the early 1900's enabled coastal cities to implement protective measures against yellow fever.

Two of Pensacola's physicians who died during this period were Theobold M. Leonard and Edmond Bouvier.

Dr. Leonard, a native Pensacolian, graduated from Springhill College. He began his medical education under the preceptorship of Dr. Hargis in 1872 and graduated from an unidentified medical school in 1873. He practiced in Pensacola until 1876 when he was appointed quarantine physician, a position he held for five years. His absence from this post in 1882 caused some speculation that the yellow fever epidemic might have been prevented if the quarantine efforts had been subject to his skillful direction.[44]

Little is known about Dr. Bouvier whom Dr. Hargis described as "a most painstaking French physician."[5] There is not even agreement about the spelling of his name. Sometimes this appears as "Edmond" and at others as "Edward." It is interesting to note that although he was one of the practicing Pensacola physicians in the 1870's, he was not an active participant in the formation of the Pensacola Medical Society. In 1886 he read a paper to the FMA on "Yellow Fever in Pensacola," a treatise in which he was in striking disagreement with other Pensacola physicians in the interpretation of the epidemic situation in Pensacola during the summer of 1883. ". . . Be as it may, however, the fever of a hemorrhagic type, intermitting fever, the dengue, a few sporadic cases of yellow fever have existed pending most of the spring and part of the fall season, but all the cases united would not be in sufficient quantity to warrant an epidemic appellation . . ."[45] Considering the need for unanimity of medical opinion among Pensacola physicians in the face of frequent adverse public reaction, one can suspect that it required courage and conviction for Dr. Bouvier to disagree with his colleagues so openly.

The Pensacola Infirmary

The Pensacola patient of the 1880's received medical care primarily in the home or in the physician's office. However, since the seamen coming into port constituted a major part of the medical clientele, there was a specific need for a facility where health care could be rendered to the acutelly ill.

The Pensacola Infirmary which Dr. R. B. S. Hargis had established in 1868 catered to the seamen coming into this port. However, fire completely destroyed the hospital in April 1884. A newspaper account of the incident indicates that arson was suspected because of previous threats. Dr. Hargis purchased 15 acres at the head of Bayou Chico near the old Cantonment and planned to rebuild a 50 bed hospital.[46]

No information is available about the Bayou Chico Hospital which existed for three years.[30] In 1888 Dr. Hargis and his son, Dr. Robert W. Hargis, moved the hospital to a new site on West Gadsden Street. The Daily News described it in great detail:

"The location of the new hospital buildings is on a high ridge, with an open and uninterrupted sweep to the Bay front and gently sloping grounds in all directions, giving the inmates full benefit of continuous breezes, with dry and healthy surroundings . . .

"The buildings consist of three comfortable, roomy and conveniently arranged cottages, connected by a covered gallery . . .

"Cottage No. 1 is occupied by the steward's family and also furnishes a large, roomy dining room (for convalescent patients), the kitchen, the steward's office and dispensary. The kitchen is supplied with a large cooking range and complete outfit of utensils, with a capacity of furnishing food for fifty people.

"The dispensary is fully supplied with all kinds of drugs, medicines, instruments, bandages, splints, plasters, ointments, salves and everything necessary for any emergency, either of sickness or surgery. In the office the steward keeps the books in which can be found full records of all patients, their reception, diseases, treatment and condition at different hours during the day and night. . . .

"Cottage No. 2. . . . is supplied with cottage bedsteads, with clean and neat mattresses, sheet covering, while a low table for medicines, water, etc. stands conveniently close to each bed, and a mosquito bar hangs overhead ready for use at any time. . . ."[38]

Cottage No. 3 was similarly furnished. An operating room and a death house completed the hospital structures.

The Pensacola Infirmary moved again in 1891 and its ownership was acquired by Dr. W. E. Anderson and Dr. Frank G. Renshaw. A "24 bed facility with ambulance service,"[47] it was located at 323 West Sarragossa Street. Marine Hospital Service patients received medical care here.

During this period, Dr. James S. Herron continued to operate his hospital on the old Panton

Leslie property. Records of its function are scanty.[30]

The need for a city hospital to provide care for indigents who did not qualify for care in other facilities received much editorial attention in 1891.[48] Local physicians and business leaders pledged support but the movement lacked organization and was not successful in achieving its objective.

Medical Society Activity

Efforts by the Pensacola Medical Society to become a viable organization met with little success until 1889. There was an attempt to revitalize the group under the presidency of Dr. R. B. S. Hargis in 1885 however, there is little data to substantiate any effective results.

When Dr. J. H. Pierpont reported to the FMA in 1890, he indicated that the old Society had succumbed to apathy. The resurgence of interest in an effective society is obviously related to the motivating influence of Dr. Pierpont. Under his direction, the Society rented an office in the Blount Building at 218½ South Palafox Street. It was furnished and decorated and served as a club room and library as well as an office. The 14 members met twice monthly.[49] The objectives were ". . . mutual edification and improvement of its members, and an interchange of views giving the results of professional observations and experiences; the discussion of matters and subjects appertaining to the medical sciences; to cultivate a friendly feeling among the members of the profession in Pensacola, and to maintain high standards of professional acquirements."[38] Miss Esther Rosenstein, a competent stenographer, was employed as a secretary to the Society.[50]

FMA Meets in Pensacola

Pensacola was chosen as the host city for the FMA meeting of 1891. Sessions were held at the Hotel Escambia. Among the physicians accepted for FMA membership was William Crawford Gorgas of Fort Barrancas. Dr. Pierpont was elected First Vice President.[51]

Dr. Gorgas read a paper, "Nine Cases of Wounds of the Abdomen," which included surgical cases from the practices of Drs. Anderson and Renshaw. In his comments Dr. Gorgas stated a surgical principle which has withstood the test of time, that penetrating wounds of the abdomen should be explored by laparotomy to determine whether more extensive injuries which require surgical repair have occurred.

Dr. Hargis was unable to attend because of illness; however, his letter to the Association contained some significant comments regarding the role of the state organization.

"This Association (FMA) must, at all times, exercise a beneficial influence, and supply a more efficient means than have hitherto been available in our State, for cultivating and advancing medical knowledge, for elevating the standard of medical education, and promoting the usefulness, honor and interests of the medical professions. . ."[52]

He continued, ". . . The establishment of the present Board of Medical Examiners, . . . has already shown itself to be a powerful protective means of rescuing the people from the hands of unscrupulous quacks . . ."

His latter comment referred to the passage by the state legislature of an act to regulate the practice of medicine in 1889. The Governor was authorized to appoint a Board of Medical Examiners in and for each Judicial District of the State.[14] Dr. R. B. S. Hargis and Dr. C. R. Oglesby were appointed to the Board in the First District, which included Escambia, Santa Rosa, Walton, Holmes, Washington and Jackson counties.

The original handwritten records of the Board are available at the Pensacola Historical Museum and provide excellent clues regarding the range of knowledge expected of the late 19th century Pensacola physician.

Dr. Thomas P. Gary, the FMA President elected for his second term in 1891, died a few months after the convention. As First Vice President, Dr. Pierpont succeeded him and presided over the 1892 meeting in Key West. Although this meeting may not be remembered for its significant accomplishments, it was unique in that part of its sessions were held in Havana, Cuba.[53]

Physicians Discuss Fees

The traditional concept of the old family doctor who never sought financial recompense for his services, received some startling blows in the 1880's. Dr. R. B. S. Hargis found it necessary to notify his patients with outstanding accounts that unless they settle "I shall try what virtue there is in the law—and if that fails, I shall get what I can for their accounts at public auction."[54]

Dr. Bouvier wrote in great detail on the subject. "It is Ecclesiastes who says:—'Honor the physician because thou hast need of him', but this may also be understood in another way: 'Honor the physician because he has need of it.' . . .

"Today, it is not rare to see months and years pass by and the gratitude remain silent . . ."[55]

1893-1902

Economic Outlook

Economic prosperity continued to prevail in Pensacola at the end of the 19th century and an intense spirit of optimism reigned. This was a city with a brilliant future, and one that beckoned to "investors and home seekers,"[56] proclaimed a local journalist as he extolled its numerous advantages and attractions.

"The city is situated on the Bay of Pensacola, about eight miles from the Gulf of Mexico, protected from the northern winds by elevated lands. A sandy soil gently sloping to the Bay with a stratum of clay varying in depth from twenty to forty feet, renders an effectual surface and deep drainage. Such physical conditions constitute nature's own system of sewerage. The general health of the city is good. Eruptive diseases are seldom seen, and then only sporadically and often traced to distant origin. Typhoid and malarial fevers are so infrequent that they scarcely deserve allusion to in this brief reference to the health of our city. Yellow fever has become distinctly an unknown entity."[56]

The writer proclaims that tourists are attracted to Pensacola because of its natural beauty, fishing and hunting opportunities, historical landmarks, and for health reasons. "Pensacola has not only the beautiful skies and the most beautiful surroundings, but the healthfulness of the area is unsurpassed, while its artesian drinking water is the purest in the world."

Pensacola's population of 24,000 depended heavily on the shipping and lumbering industry for continued support. There appeared to be no concern that this prosperity would ever lessen. "Pensacola's commerce will steadily increase for many years to come. The harbor of Pensacola is the safest, deepest, most approachable and best landlocked harbor in the South, with unlimited wharf facilities for loading and unloading vessels. A depth of channel that permits ships to enter and depart at all tides, the harbor is thirty miles long, from two to five miles wide, and varies in depth from fifteen to thirty feet in the channel and near the wharfs [sic] so that the heaviest sea going vessels can lie along its water front for miles. The lumber and timber interests of Pensacola rank first in importance, and the almost inexhaustible forests of this section has attracted the attention of the whole country."[56]

In retrospect one is tempted to criticize some of these exaggerated claims and anticipations as unrealistic. However, in view of Pensacola's terrorizing history of severe epidemics that had wreaked havoc with the population and the commerce for many decades, there was just cause for rejoicing at the end of the 19th century.

Since 1883 Pensacola had been spared the painful agony of a yellow fever epidemic. Although the dreaded disease had affected other Florida towns during this period, it had failed to penetrate this thriving community. There is no evidence of any careful scientific inquiry into this blessing of fate. It was accepted without question.

Smallpox

Smallpox posed a potentially serious threat to Pensacola in the spring and summer of 1896. The incidence of the disease in New Orleans had been cause for watchful concern.[57] Its appearance in Pensacola in March touched off a heated controversy among the members of the Board of Health.

The initial case of smallpox involved an itinerant who was sent to the county poor farm where he was treated by Dr. Robert W. Hargis. The only medical member of the Board of Health, Dr. Frank G. Renshaw, questioned the wisdom of sending this person to the county facility rather than to the quarantine station. He also stated he had received no official notice regarding the case and its disposition. The local newspaper provided the forum for the exchange of vituperative comments between Mr. B. R. Pitt, President of the Board of Health, and Dr. Renshaw.[58]

Fortunately, the incidence of the disease was sporadic and no serious consequences resulted; however, the lack of harmony among Pensacola's guardians of public health—the Board of Health—was brusquely exposed. An editorial in the Daily News provided the only objective commentary in this verbal barrage.

"It will doubtless occur, also, to a reflecting public as somewhat strange that the Board should retain the services of a physician in whose ability as a small pox detective it has expressed a want of confidence; but it will not seem strange if the physician in question, recognizing the gratuitous character of the reflection on his ability, should relieve the Board of a further embarrassment in the case by gracefully putting his resignation in the hands of his employers. He should not, however, take such a course. At this critical juncture in our health affairs, when possibly, no other self-respecting physician would accept employment from such a source, it becomes the duty of some

one to act in a self-abnegatory manner, and the sacrifice of pride by whoever shall make it on the altar of public duty will doubtless be fully appreciated by a suffering people. . . . ."[59]

Yellow Fever Epidemic of 1897

Pensacola had a 14 year respite from yellow fever. In September 1897, however, there was reason to suspect that this good fortune might be in jeopardy. There were cases of yellow fever in Ocean Springs, Mississippi. The illness gradually spread to New Orleans, Montgomery, Mobile and eventually to Flomaton, Alabama, the junction of the Louisville and Nashville Railroad, about 40 miles from Pensacola.[60]

Despite the disturbing reports, Pensacola physicians maintained an optimistic attitude. At the September meeting of the Pensacola Medical Society "the physicians were unanimous in their declaration that the present month of September is the healthiest ever known here."[61]

Dr. Joseph Y. Porter, State Health Officer, who had come to Pensacola to investigate the yellow fever scare, was a guest of the Society. He was assured that Pensacola was the zenith of good health.

"Dr. Renshaw opened the discussion by saying that he had very little sickness to report in his practice—in fact there was such a dearth of cases that he was at a loss in reporting upon any particular disease. 'During a practice of 15 or 16 years,' said he, 'I have never known such perfect health in the city.'

"Dr. Pierpont said he had always regarded September as the sickliest month of the year, but the present month has been the healthiest ever known. He thought that the city authorities deserve great credit for this state of affairs, especially Capt. Wm. Hayes, Chairman of the Sanitary Committee of the city council, who had kept the city in most excellent sanitary condition. There had been but very few cases of malarial fever, and these of a mild type and only one or two cases of typhoid fever."[61]

In his address to the Society at this meeting, Dr. Porter complimented Floridians on their behavior during this threatening period. ". . . the people of Florida have acted sensibly in the matter; only a few have been at all nervous and it is very probable that if the neighboring Gulf states had the same system as Florida, there would not be the senseless quarantine regulations now in vogue at some points."[61] He was optimistic that Florida would be safe from the fever until the arrival of the first frost.

The age old mystery of the origin of yellow fever was explored at this medical society meeting. "Dr. Anderson assumed the position that it was not produced by germs, but by a poisonous gas, while Dr. Renshaw held to the germ theory. Both physicians argued strongly in favor of their theories, but both admitted that they could not yet speak positively . . ."[61]

One detects a note of journalistic irony in The Daily News that carried the account of this September 1897 medical society meeting. Directly below this article was an advertisement that proclaimed: "Yellow Fever Germs Breed in the Bowels. Kill them and you are safe from the awful disease. Cascarets destroy the germs throughout the system and make it impossible for new ones to form. . . ."[61] For the small sum of 10¢ one could avail himself of protection against Yellow Jack at the local drug store!

The Commanding Officer at Fort Barrancas, Capt. Junius W. MacMurray, did not share the high degree of optimism of the Pensacola physicians regarding the threat of yellow fever. He considered it imperative to move his command to the safety of Chickamauga Park. However, he reluctantly yielded to the advice of Capt. William C. Gorgas, the post physician, and that of Dr. Porter, who had remained in Pensacola to be in close proximity to the epidemic areas. Both agreed that such a move was somewhat premature.

Capt. MacMurray subsequently wrote in December that Dr. Porter ". . . maintained along the state line, sanitary pickets after the manner of a 'shot gun' quarantine. He visited the post frequently and kept in close touch with the command. He wrote me a letter thanking me for remaining here notwithstanding my conditional authority to remove the troops. Merchants boasted that it was 'a feather in their caps' that the United States troops were not withdrawn as usual. I was never convinced that my deliberately and studiously formed judgment was wrong, and notwithstanding my illness, was unwilling to leave my men here as a matter of *esprit de corps*. (Capt. MacMurray does not clearly identify his illness that was manifested by gastrointestinal symptoms and weight loss.) Finally, the quarantine which had grown irksome and a serious injury to local commerce, was relaxed and its termination at an early date announced and there seemed assurance that we were providentially saved this year."[62]

The anxiously awaited frost failed to materialize in November, and the fears of the populace were aroused when a yellow fever death occurred in Pensacola on November 14. The victim, a Mr. Goldberg, repaired and sold secondhand shoes in a shop near the railroad station in Pensacola. Dr. Gorgas recounted that, "All persons who were known to have come in contact with him were isolated, and no further cases occurred. The State Health Officer had several house to house inspections of the city, but no cases at all suspicious were found. Nor could he find anything suspicious in the mortuary records of the town."[63] Mr. Goldberg was Pensacola's only known case of yellow fever. About five cases were recorded at Fort Barrancas.

Although the extent of the illness was minimal in numerical terms, the fear that it inspired was widesweeping. Dr. Gorgas commented in his report that "The fear of yellow fever is so great through all this country, much greater than any of the other epidemic diseases, that I think keeping up of the morale of the people is more important than the slight service intra-garrison quarantines do. It cannot fail to have a depressing effect upon all concerned, to see the sick and their attendants avoided and looked upon with such dread, and the dead carted away at night and buried without ceremony. The risk is so small that I would have less of this grewsome [sic] business. Experience has taught that if you depopulate, (the men were moved to tents a mile away from the post) you can be pretty liberal in your communication with your camp, and run little risk of infecting it."[63]

The appalling experience of burying the dead in the middle of the night at Fort Barrancas must have etched a painfully deep impression on Dr. Gorgas. "The yellow-fever doctor in those days had more than merely medical duties to perform; not infrequently he was undertaker, grave-digger, even clergyman; so great was the fear of contagion that funerals were held at midnight, and even the family kept at a distance. One night at Barrancas, Dr. McCulloch, one of the Army physicians, and Mr. Richard Gorgas, the Doctor's brother, were awakened from troubled slumbers by Gorgas, who asked them for a prayer book. Soon afterward, from the direction of the hospital, they could hear the measured tread of pallbearers—hospital attendants—as they passed on their way to the cemetery in the woods. The two men witnessed the scene from the back porch. In the light of the swinging lanterns that aided a cloud-obscured moon, the cheap, black-covered coffin on the attendants' shoulders was dimly visible. Gorgas afterward described the horrible details in which he took part—laboriously digging the grave in the wet, heavy soil; wrapping the corpse in its simple white shroud; filling the unoccupied spaces of the improvised coffin with quicklime; the difficult interment and the filling up of the grave, and the reading of the burial service by the light of the lantern."[64]

Pensacola Physicians

Dr. Robert W. Hargis, son of Dr. R. B. S. Hargis, died in 1899 at the age of 52. No details of his formal education are known. As a youth, he ran away from home, joined a military unit in Virginia and fought throughout the Civil War.[65] As a physician in the 1880's in Pensacola, he assumed charge of his father's hospital—The Pensacola Infirmary—at its Bayou Chico location[30] and then at its Gadsden Street location.[38] During his medical career, he was a member of the Board of Health, the physician in charge of the County Pest House and the Escambia County Health Officer. His enthusiasm for involvement included Pensacola politics as well as medicine.[65]

By 1898 there were about 20 regular physicians in Escambia County. Few wrote any personal reminiscences about private medical practice in Pensacola in the late 19th century. However, a newspaper writer's description of the new office suite of Dr. C. F. Marsh enables one to speculate about activity in a local physician's office in the prosperous 1890's! His special area of medical interest was "Chronic Diseases, Diseases of Women and Children, Rectal Troubles and Difficult Surgery."[66]

The Physician's Office

The elegantly furnished reception room contained the physician's office equipment, his medical library and comfortable chairs for his patients. "The second room contains, besides a large glazed case filled with all manner of surgical instruments and appliances, no less than five different kinds of electrical and magnetic machines—an Endiscope [sic], a Faradaic [sic], a Cautery, and an ordinary galvanic battery, as well as a small battery for the removal of farcial [sic] blemishes, etc."

"The operating room is supplied with a very complete Allison operating table, and still another room contains a large electro-thermal bath cabinet, arranged so as to apply the electric current to any part of the body."[66]

Evidently not all Pensacola physicians practiced amid such luxury. In an interview with Dr.

Pierpont in 1939, he claimed that, "A doctor considered himself pretty well set up if he found an office in the back of a drug store, or if his home were close enough to town to make it practical to maintain his office there."[50]

Hospital care was available to Pensacolians at the Pensacola Infirmary, 323 West Sarragossa Street. In 1896 it could accommodate 35 patients.[67] Evidently its location was not considered the most desirable section of the city. It was close to the waterfront, saloons, and boarding houses. Mrs. Leora Sutton, a local amateur archeologist, relates that when she was digging in the vicinity, she inquired among old Pensacolians about the old Marine Hospital. One response was "that no self respecting lady ever went into that part of town. . .!"[68]

Miss Crowell and St. Anthony's Hospital

About 1896, Miss F. Elizabeth Crowell, a young nurse who had recently graduated from St. Joseph's Hospital in Chicago,[69] came to Pensacola to work at the Pensacola Infirmary and lived there as well. Dr. and Mrs. Anderson became concerned about this "pretty young girl" down there with all those rough seamen, so they brought her home to live with the Anderson family.[70]

In 1899 Dr. Warren Anderson purchased Winter Rest—a tourist hotel—on West Garden Street and moved the Pensacola Infirmary to this new site. In accordance with Mrs. Anderson's wishes, the hospital was renamed St. Anthony's in honor of this Roman Catholic saint to whom she had a great devotion.[70] The frame structure was remodeled to accommodate 40 patients.[71,72]

St. Anthony's experienced a most successful first year of operation. At the annual stockholder's meeting in 1901, Miss Crowell, Hospital Superintendent and Secretary-Treasurer, reported on the accomplishments of the year. ". . . the hospital was established and has been maintained as a strictly first class institution, and as such, has received the recognition and patronage of the leading practitioners of the town; and secondly, to the excellence of our nursing staff, which we have recently been obliged to increase, owing to the pressure of work both within and outside of the hospital."[73] She further commented on the public's realization ". . . of the necessity for intelligent, trained nursing in all cases of serious illness."[73] This imposed a great demand on the hospital staff for trained nurses in the community and Miss Crowell determined to meet the challenge; she established Pensacola's first training school for nurses at St. Anthony's Hospital in the early 1900's.[74]

Unfortunately, no further information regarding this training school has been uncovered; however, in view of Miss Crowell's subsequent accomplishments, one seems justified in speculating that this fledgling school may have reflected some of the most innovative concepts in nursing education of that era.

Miss Crowell left Pensacola in 1905. In 1917 she went to Europe with the Rockefeller Foundation's Tuberculosis Commission and contributed brilliantly to the work of this group. As part of the Rockefeller team, she was invited to study nursing needs in eastern and central Europe. During her 23 years of service ". . . modern schools of nursing were aided in nine European countries to prepare nurses for public health work. Health centers, urban and rural, were established. Central bureaus of nursing were organized in three national governments . . ."[75] This intelligent and creative young lady who had once implemented a nursing idea in Pensacola was accorded further honors when she received medals of recognition from the governments of Rumania and France. Miss Crowell died in Italy in 1950.

The U. S. Marine Hospital Service maintained a service for marine patients at St. Anthony's with Dr. J. Whiting Hargis in charge.[72]

In 1900 Pensacolians continued to express the need for a city hospital to care for its "destitute sick and injured."[76] Lack of funds prohibited the construction of such a facility. Consequently the city and county jointly contracted with St. Anthony's hospital for the use of three beds for $750 per year.

Dr. J. H. Pierpont and Medical Society Activity

The Pensacola Medical Society continued its arduous task of trying to develop into a strong, effective organization. When Dr. Juriah H. Pierpont reported to the FMA in 1895 he lamented that, "Our Society has unfortunately run down somewhat during the past year. We have lost three of our members by dropping them. They seemed to lose interest and failed to attend the meetings, and were accordingly stricken from the roll . . ."[77] Membership in the society was not restricted to Pensacola physicians but extended to regular physicians in the surrounding towns of Milton, Bluff Springs and Warrington.

Although data on the medical society activity is scarce, there is evidence that the group met regularly during this era. The Daily News carried

notices of these twice monthly meetings from 1898 to 1902. The fact that some local physicians presented scientific papers at the FMA suggests that there were discussions pertaining to medical science at these society meetings.

In 1893 Dr. Charles R. Oglesby presented to the FMA a paper entitled "The Therapeutics of Ergot In the Reduction of Uterine Fibroids."[78] At this same session Dr. Pierpont read a paper entitled "Some Practical Remarks on Chloroformization."[78] He related, "It is my practice to reassure patients by giving a hypodermic of morphine and atropine in a menstruum of whisky [sic] or brandy, and at the same time, to tell them that the danger from the chloroform has been removed; as it has, in my opinion, since it unquestionably lessons [sic] the stage of intoxication, adds tone to the cardiac muscles, quells cerebral excitement, lessons [sic] the susceptibility to shock, relieves pain after anesthesia, and from an economical point of view, less chloroform is required after complete anaesthesia [sic] has been induced."[78]

At the 1901 FMA meeting, Dr. Pierpont read a paper entitled "A Plea for the More Common Use of the Microscope in Diagnosing Diseases of the Urinary Passages."[79] His selection of a subject becomes quite impressive when one considers some of the attitudes of physicians of that day to scientific medicine. A 1902 publication warned physicians not to become involved in medical science! "Do not allow yourself to be biased too quickly or too strongly in favor of new theories based on physiological, microscopical, chemical, or other experiments, especially when offered by the unbalanced to establish their abstract conclusions or preconceived notions, or by those who have blindly identified themselves with the latest medical novelty."[80]

Medical Licensure

The problem of medical licensure intensely concerned Dr. Pierpont. At the 1895 meeting of the Florida Medical Association, he read a paper entitled "The Association of Medical Examining Boards." He pointed out that the seven Judicial District Examining Boards that had been created by a Legislative Act in 1889 functioned independently of each other without conforming to any established guidelines. "Prior to June the 15th, 1894, the several Boards conducted their bi-annual examinations whenever it best suited their convenience, and without any regard towards cooperation with the other Boards, which would frequently be in session a few days or weeks afterwards, making the interval between the sessions very short. This gave valuable opportunity to applicants who had previously failed before one Board to present themselves before another Board and demand another examination without the knowledge of the Board by whom they had just been examined, or the one before whom they next applied . . ."[77] There was wide variation in the administration of the examinations. "One Board used a system by which the applicant was required to draw ten questions on each branch out of a lot of several hundred that covered the branch from beginning to end. Another Board extemporized the questions for each applicant and examination."[77] The granting of temporary certificates was another sensitive area. "One Board went even so far as to grant temporary certificates to applicants who failed even to qualify; the idea being that the applicant was entitled to the certificate. This enabled holders of temporary certificates to establish themselves in practice and public confidence, and when at the regular meeting of the Board, he was rejected, the hue and cry was raised that he was being persecuted by the bad doctors, who were from selfish motives trying to debar him from practicing . . ."[77] Dr. Pierpont's criticism was not restricted to licensing procedures; medical education of that day merited commentary. "The noble profession, of which we are proud to be called members, is being besmirched and trampled in the dust by these disreputable and irresponsible medical colleges, and if examining boards will stand firm and fix their standards commensurate with the requirements of modern and refined medical education, reputable colleges will raise theirs to a proportionate degree, while the institutions representing the enemies of medical science and progress will cease to exist."[77]

In order to correct some of these deficiencies, representatives of the various medical examining boards met and formed the Association of Medical Examining Boards. Guidelines were established regarding examination dates, examination methods and standardization of questions. Although this was not the ideal solution, it represented a vast improvement over the previous arrangement.

This marked the beginning of a long period of effort on the part of Dr. Pierpont and other Florida physicians to secure legislation to create a single State Board of Medical Examiners.

In 1896, Dr. Pierpont, Chairman of the FMA Committee on Legislation, reported on the failure of an FMA sponsored bill to create a Board of

Medical Examiners at the previous session of the State Legislature. His argument for an improved system of medical licensure was strikingly illustrated by a letter that had appeared in a Pensacola newspaper.

To Whom It May Concern:—

If there be any physician in or out of the State of Florida who anticipates locating in Pensacola to practice medicine, their friends will do well to advise them not to come before this Pensacola Board to be examined. Not one has passed the present board, who expressed himself as locating here, and not one of them has failed to get a certificate from other boards, where honesty and professional ability existed. The best citizens advised me to go to some other board where I might get justice; I found they knew whereof they spoke. It is reasonable to surmise the local board did not intend to antagonize with any more doctors in the city, and those who desired locating in the piney woods uniformly pass with a complimentary grade—see. [sic]

The direction of the smoke will give you the point from whence the wind cometh. The presumption of this board is unbounded, who,—but they—would write upon a postal card, publicly, so anyone could read, their extreme low rating of an applicant, and the presumption is only magnified when this card is sent to another board with a telegram dictating to them what to do in the case, etc. They, too, assume a higher prerogative than the National Association, and boast of plucking men because they do not belong to their ideal school, while the law recognizes no one school more than another. When that school has conformed to the regulations of the National Association, all have an equal right, and should be treated impartially, to say the least of it, regardless of race, color, creed or politics. The standing of the school is decided by the Association, and the duty of the board is to see if the school is on the National list, and if so, to give the applicant an impartial examination, consistent with justice, and when there is reason to believe that the Board over steps its formation it should be investigated, and if justifiable a prayer sent to the Governor; for much injury can be done by such a board to innocent, proficient and worthy young men, after spending time, money and talent, only to be thrown by men who are prejudiced.

It is hardly reasonable that every man, without an exception, four or five in number, should be so deficient, coming from the leading three schools recognized by the National Association, and yet in this board's opinion deficient. Before educated and honorable boards, these same men pass complimentary examinations. Something radically wrong—and in conclusion, remember to direct your friends where they may get justice and prevent antagonism with that which approveth evil.

Respectfully,
T.J.W., M.D., D.D.S.
[T. J. Welch, M.D. DDS][42]

Despite intensive efforts to create a State Board of Medical Examiners, sufficient legislative support failed to materialize during this era.

Dr. Pierpont Elected FMA President—Second Time

In 1902, for the second time in his medical career, Dr. Pierpont was elected President of the Florida Medical Association. It was a unique set of circumstances that unexpectedly conferred this honor upon him. Both the FMA President and Vice President were unable to attend the meeting because of their personal losses incurred in the disastrous Jacksonville fire of 1901. The membership elected Dr. Pierpont to preside at the 1902 meeting, and to serve as President of the organization from 1902 to 1903.[79]

1903-1912

The destructive forces that had regularly terrorized Pensacola in the 19th century seemed destined to repeat the cycle as the first few years of the 20th century slipped by.

Smallpox

In 1903, smallpox threatened the city when some itinerant laborers from Alabama transmitted the infection into Northwest Florida. A well-organized immunization program by city, county and state health officials arrested the spread of the disease.[81]

Last Yellow Fever Epidemic

A final challenge was presented by the dreaded Yellow Jack which, unlike previous epidemics, was carried into the city by railroad and not by ship. In mid-July 1905, an estimated 400 to 500 Greeks and Italians traveled to Mobile and New Orleans on an excursion train. Those who visited in the Crescent City, it was subsequently learned, had been exposed to yellow fever. This was a distressing realization for Dr. Warren E. Anderson, the State Board of Health agent in Pensacola. Two suspicious cases of fever were observed in mid-August; three definite cases of yellow fever were confirmed in late August.[82]

Prompt measures were taken to confine the illness to the East Government Street area where the patient lived. A sanitary cordon was established around the section bounded by Romana Street on the north, Alcaniz Street on the east, Church Street on the south, Jefferson Street and a line through Cushman's Alley to Romana Street on the west. Police guards permitted only authorized personnel to enter or leave the quarantined area. House to house inspections were conducted to detect further yellow fever cases. Houses were screened and fumigated with pyrethrum. Mosquito breeding sites were destroyed and citizens slept under nets, as added protection against the mosquito. The determined efforts of the health inspectors to rid the city of mosquitos were not lauded by everyone. Dr. James S. Herron refused to have his premises inspected! He alleged that, "he was standing on his constitutional rights and exercising the prerogative of a free American citizen, claiming the right given to every American

under the Constitution of the United States."[83] He was ultimately fined $25.[84]

Despite a carefully designed plan to confine the disease to a small area, the fever eventually spread throughout Pensacola. Many persons had anticipated the confinement of quarantine when yellow fever suspicions were first expressed and had quietly slipped away to other sections of Pensacola. Another possible contributing factor was the lifting of some quarantine restrictions when the infection appeared to be subsiding. The epidemic faded in late November. There had been 1,052 cases with 150 deaths.[85]

Nursing Measures at St. Anthony's Hospital

A remarkable observation was Pensacola's success in confining the illness to this city. Dr. Joseph Y. Porter, State Health Officer of Florida wrote:

> An interesting as well as instructive feature of management in the epidemic at Pensacola was the freedom from infection enjoyed by the nurses at St. Anthony's Hospital. The treatment of cases here was confined to the indigent, the homeless and friendless class. A long ward, with smaller rooms opening into it, were all wire screened and then thoroughly fumigated to kill all mosquitoes. Only one entrance was given to these rooms, and that through a wire-screened vestibule cage with two doors opening in opposite directions. The nurses of the hospital were nonimmune young females. Although there were virulent cases of yellow fever treated in these wards, none of the nurses contracted the disease, nor did any other of the hospital force. As proving conclusively the correctness of the law of the transmission of yellow fever by the mosquito alone, mention is made of several cases of malarial fever, which in a hurried diagnosis were sent to the hospital under suspicion of yellow fever, and which were treated in the ward with the yellow fever cases and beside yellow fever patients, who recovered from the malarial attack, but never contracted yellow fever.[82]

The State of Florida spent over $40,000 to control the epidemic in Pensacola and to prevent its spread to other parts of the state.[82]

"Bosso's Blessing"

Reflections on the yellow fever epidemics in northwest Florida would be incomplete without brief mention of "Bosso's Blessing to Mankind"—a patent medicine claimed to prevent yellow fever. Dr. Samuel Clarke Bosso, an Italian physician whose medical background is obscure, came to Pensacola in 1882.[86] His patent medicine was widely advertised, particularly when yellow fever "season" approached. He, himself, died of yellow fever in 1883, a rarely acknowledged fact. Dr. Daniel Guiteras, U.S.N., wrote that, ". . . before he (Dr. Bosso) died, he wanted me to sign a certificate, stating that he had not died of yellow-fever, for, said he, 'If I die of yellow-fever, people will not buy my medicine any more!'"[87] Evidently the success of his patent medicine was not adversely affected. During the 1905 epidemic, the current promoters of the medicine purchased half page ads in a Pensacola newspaper and daringly promised a $500 reward to anyone who took "Bosso's Blessing To Mankind" according to the directions and nevertheless developed yellow fever![88] Such a resolute promise provided an interesting paradox alongside articles such as Dr. Rudolph Matas' "The Transmission of Yellow Fever and How to Nurse It,"[89] and the U.S. Marine Hospital Service's circulars on screening, mosquito control and other yellow fever prevention measures.[90]

Quarantine Station

The Santa Rosa Island Quarantine Station, a very significant facility in the annals of Pensacola yellow fever history, was sold to the State of Florida for $20,000 in 1903. It was subsequently transferred to the U.S. Marine Hospital Service.[91]

1906 Hurricane

Less than a year after Pensacola was tormented by yellow fever a destructive hurricane claimed 32 lives. Damage estimates were over $3,000,000.[92]

Drug Addiction

A medical problem of serious proportions that received less public attention in this era than yellow fever and other epidemic illnesses was drug addiction. An unidentified Pensacola lawyer expressed concern about the availability of cocaine and morphine. He commented in a local newspaper that, "I have somewhat interested myself in the matter and conclude that there is no restriction by the city on the sale of the dangerous drugs. In one of the drug stores on this street, I stood a few moments and saw no less than seven women go in and get a supply, which in each case was sold without question. There is a prohibitory state law, but it seems to have become a part of history so far as its enforcement is concerned."[93] Advertisements for a sanatarium in Louisiana where one could obtain treatment for drug addiction appeared regularly in local newspapers.[94] The country's one million drug users were even offered mail order therapy by a New York association![95]

Outstanding Physician Activity

Several new physicians joined the Pensacola medical community during this decade; some made outstanding contributions during their long years of service.

In 1905 Dr. John Samuel Turberville began the practice of medicine in Century, a small lumber mill community north of Pensacola. A native of Claiborne, Alabama, he graduated from the medical school of the University of Alabama in 1902. In 1907 he acquired a sanatorium which he rebuilt into the Turberville Hospital, a facility which brought medical care to the people of the Century area for more than 50 years. Dr. Turberville served as President of the Escambia County Medical Society and of the FMA in 1940. He died in 1946.[96]

Dr. Stephen Russell Mallory Kennedy was born in New Orleans in 1878 and graduated from the medical school of Tulane University in 1903. He was associated with the Louisiana State Board of Health for a short time. He came to Pensacola, the home of his late grandfather, Stephen Russell Mallory, former Confederate Secretary of Navy. In 1906 Dr. Kennedy assumed charge of the U. S. Marine Hospital Service here. In 1917 he was commissioned in the U. S. Army Medical Corps. While serving in France he was assigned to assist the British Forces and was awarded the British Military Cross for bravery in action. He was married to the former Sarah Logan of Virginia. His only son, Thomas, still lives in Pensacola.[97]

In 1908 Dr. Clarence E. Hutchinson returned to practice medicine in his home town. He was the grandson of Emory Fiske Skinner, a prominent late 19th century Pensacola resident. Dr. Hutchinson graduated from the medical school of Tulane University in 1905. Following graduation he was appointed Assistant House Surgeon and then Senior House Surgeon at Touro Infirmary in New Orleans. In April 1908 he was appointed Superintendent of Touro, a 200 bed hospital with clinic facility that treated about 3,000 patients per month.[98]

Following a trip to Europe in late 1908, Dr. Hutchinson returned to Pensacola and became associated with a movement to establish a modern hospital here. These efforts culminated in the establishment of the Pensacola Sanitarium, which will be described subsequently.[99]

Another well remembered physician who came to Pensacola during this era was Dr. Mozart A. Lischkoff. He was born in Woolsey (now Warrington, Florida) in 1890. He graduated from Tulane University Medical School in 1910 and did residency at the Ear, Nose and Throat Hospital in New Orleans for a year. After a year's study in Vienna, he returned to Pensacola and opened an office in 1912.[100]

St. Anthony's Hospital Closes; Becomes Pensacola Hospital and Training School

The need for a hospital facility to provide medical care for the indigent became apparent again in 1906. In January of that year, the stockholders of St. Anthony's Hospital voted to liquidate the corporation. The published account explained that, ". . . [the] large amount of charity work in the city makes it impossible to conduct an institution of this kind on a self sustaining basis."[101] This disclosure was of great concern to Dr. J. Harris Pierpont, the city physician. He proposed that plans for the new city jail include two hospital wards and an operating room.[102]

Evidently this proposal was never implemented. St. Anthony's Hospital moved to the northwest corner of Reus and Strong Streets on North Hill and became known as the Pensacola Hospital and Training School for Nurses.[103] Dr. Warren E. Anderson was the surgeon in charge. In 1907 the City Board of Health officials negotiated with Dr. Anderson for the use of beds at this hospital for city patients.[104] Dr. Anderson maintained this facility until it was absorbed by the Pensacola Sanitarium, a hospital which opened at 340 West Garden Street in January 1909.

According to A. C. Blount, prominent banker and member of an old Pensacola family, the building which housed the Pensacola Sanitarium was originally located on the present site of the Barnett Bank.[105] It was first a tourist home and then St. Anthony's Hospital. It was moved to the corner of Garden and Devilliers Street and converted into a hospital for a second time.

Pensacola Hospital Described

The Sanitarium staff invited Pensacolians to an open house on January 14, 1909 and the response was enthusiastic. The visitors were impressed by the facilities they viewed—an x-ray or therapeutic room which contained the latest appliances for the administration of electricity, a laboratory complete with "freezing apparatus for the examination of tumors, excretions and pathological specimens,"[106] an emergency room and a well equipped operating room. It could accommodate 20 patients. Miss Dewitt Dillard was in charge of the staff of six nurses who came from Touro Infirmary in New Orleans. Miss Dillard shared responsibility of the Training School for Nurses with the hospital superintendent.

Among the members of the stock company that owned the Pensacola Sanitarium were Drs.

Daniel W. McMillan, Clarence E. Hutchinson and Marian E. Quina.[99]

Mission Hospital and Bryans Sanitarium

Local citizens maintained interest in establishing a charity hospital to accommodate patients with little or no funds. In 1910 Mission Hospital, usually referred to as "Charity Hospital" a 30-bed facility opened on North Hill. Projected plans included a training school for nurses. Local physicians served on the Board of Directors. Although care of the indigent was a primary objective, private patients were accepted.[107] However, the institution remained in financial distress during its few years of existence. In 1911 it changed its name to St. Luke's Hospital. Patients capable of paying for hospitalization—and their support was needed—were reluctant to enter a hospital with "charity" patients.[108]

From 1903 to 1909 Dr. Robert Lee Bryans maintained a private sanitarium in Pensacola. In 1903 the building, located at the southwest corner of Garden and Baylen Streets, was destroyed by fire. One patient died in the blaze.[109] The Sanitarium was then located at 100 East Wright Street[110] and in 1907 it was moved to 928 East Gadsden Street.[103] Information is incomplete regarding the closing of Mission Hospital and Bryans Sanitarium.

Pensacola Medical Society Becomes Escambia County Medical Society

In 1903 Dr. Louis deM. Blocker reported to the Florida Medical Association that the name of the Pensacola Medical Society had been changed to the Escambia County Medical Society, to conform to the reorganizational plan recommended by the American Medical Association, and a charter was requested from the State Association.[111] Reports in the Transactions of the Florida Medical Association during this decade (1903-1912) indicated that membership in the Escambia County Medical Society fluctuated from 12 to 30 members, and that society activity was somewhat languid.

FMA Meets in Pensacola

In 1909 the Florida Medical Association held its annual meeting in Pensacola.[112] In his welcoming address delivered at the City Hall, Dr. Warren E. Anderson commented on the history of the Escambia County Medical Society and the influence of Dr. J. Harris Pierpont in revitalizing the society. He made proud reference to a former member, Dr. William Crawford Gorgas, who was President of the American Medical Association in 1909.

Activities of Dr. Pierpont

Dr. J. Harris Pierpont's interest in maintaining an effective physicians' organization was not

Pensacola Sanitarium at northeast corner of West Garden at Devilliers Street, 1909.

limited to the county level; he contributed his time and talents to the work of the state association as well. He served as Councillor from the First Judicial District to the Florida Medical Association and as a member of the Committee on Public Policy and Legislation throughout this era, 1903-1912.

Dr. Pierpont's dedication to the objectives of the Committee on Public Policy and Legislation inspired the theme of his President's Address to the FMA in 1903. He dwelt on the need for legislation to create a State Board of Medical Examiners that would elevate the qualification standards of physicians applying for licensure in Florida. He also urged strengthening state and county societies by enlarged memberships.[113]

A bill creating the recommended Board of Medical Examiners was introduced in the Senate by W. A. Blount of Escambia County in 1903 but failed to receive sufficient support for passage. Dr. Pierpont wrote each opposing legislator to determine specific reasons for the bill's failure. The replies were quoted in his 1904 report to the Florida Medical Association: ". . . The measure referred to is taken as an attempt to formulate a medical trust, and to exclude all methods of healing not authorized by the Board formed by the proposed bill." ". . . I fought the bill for a Board of Medical Examiners as a piece of vicious [sic] legislation—a bill to build up a trust—and aimed directly against the interest of the poor man. My idea is that a business that has any merit in it needs no legislation to protect it and such a bill as your association tried to put through the Florida Legislature seems to me to be a virtual confession of your lack of merit." ". . . My constituents, or at least 90 per cent of them, was [sic] opposed to the bill." ". . . it in some way aimed a blow at some of the schools of medical science, and particularly at Christian Science, and that it was a concentration of power that was not necessary." "I consider it a crime against the country people to restrict the practice of medicine to those highly educated." "We need more doctors who will reside in the country. And it is better that we have second class than none at all."[111]

In concluding his report, Dr. Pierpont stated, "It is plainly evident from these replies that the representatives were not properly informed beforehand by the physicians in their respective counties, consequently were easily led to believe what our enemies saw fit to tell them."[111] He urged physicians to contact their respective state legislators and exert positive influence regarding medical legislation.

Osteopath Wins Court Case; Practicing Without a License

The need for more effective medical legislation was demonstrated in Escambia County in 1903 when legal action was brought against Dr. C. E. Bennet, an osteopath, for practicing medicine without a license. The suit was filed at the instigation of the District Board of Medical Examiners and the County Medical Society. Dr. Warren E. Anderson wrote, ". . . despite the zeal and ability displayed by our attorneys, the number of decisions of supreme courts of various states, based upon laws similar to our own, the Judge (E. D. Beggs) ruled against us on the question of law, and not of fact as to the illegal practice of medicine."[111]

When Dr. Pierpont spoke to the FMA on "Medical Legislation"[114] in 1905, he directed some harsh criticisms at fellow physicians. The real cause of the failure to enact medical legislation ". . . is found with the individual medical man, who evinces the greatest indifference to the welfare and elevation of his profession by staying out of his county and state medical societies." "If Lot were alive today, he would experience greater difficulties in finding zealous, progressive and self-sacrificing medical men than just men with whom he hoped to save the doomed city of Sodom!" He recommended that physicians should become involved in local public affairs and, "aid in shaping the destinies of his people as well as the interests of his profession."

In 1905, a compromise bill creating a State Board of Medical Examiners was passed by the Florida Legislature.[115]

1913-1923

Pensacola Hospital Established

In 1914 the Sisters of Charity of St. Vincent de Paul from Emmittsburg, Maryland were invited to Pensacola to participate in the establishment of a modern facility—the Pensacola Hospital.

These Roman Catholic nursing sisters were not strangers to this area. In 1861 a small group of these nuns had come to Pensacola to give nursing care to the Confederate soldiers in Warrington. The heart-rending scene of suffering and squalor which they encountered at the military hospital was graphically described in a letter written by one of the nuns:

. . . on one occasion over 8 hundred came in with measles & not a vacant bed in the house, they were satisfied to lie on the floor with their knapsack under their poor heads & one blanket for covering, & it fairly alive with vermin & fleas but not a complaint escaped from them. A number of them took other diseases in the hospital & died as they had lived.[116]

In 1915 the nursing sisters arriving in Pensacola discovered a remarkably different set of circumstances. Pensacola was an expanding city and the health needs of the area warranted a larger, better equipped hospital than was presently available at the Pensacola Sanitarium. A committee of responsible citizens including Rabbi William Ackerman, Max L. Baer, the Rev. T. H. Kennedy, Thomas W. Brent, P. K. Yonge and Bishop Edward P. Allen of Mobile had carefully studied the situation. Funds had been raised, property had been purchased on Twelfth Avenue at Gonzalez Street, and the nuns accepted the invitation to build a hospital[117]

Dr. S. R. Mallory Kennedy proclaimed that the Pensacola Hospital was a physician's dream-come-true. He wrote that, "for years surgeons have deplored the fact that operative cases were being taken every day to some distant city where better facilities could be found. Many desperately sick patients have preferred to risk the jolting and jarring incident to a railroad journey, to being operated upon at home, not because they lacked faith in their physician, but because the hospital facilities afforded them were poor."[117]

Mrs. E. P. Nickinson, a native Pensacolian, corroborates Dr. Kennedy's comments about the inadequate surgical facilities in the city prior to 1915. She vividly recalls the drama surrounding her own appendectomy in her home on North Baylen Street when she was a young girl. Even the large surgical lamps were brought in by Dr. Clarence Hutchinson to transform her bedroom into an operating room.[118]

The Pensacola Sanitarium closed when the Pensacola Hospital opened on September 1, 1915.

A training school for nurses was established at the new hospital shortly after it opened.[117] The student nurses assumed an active role in assisting local physicians in rendering health care. Mrs. Marguerite Skotsky Pfeiffer, a 1919 graduate of the school, remembers that student nurses assisted physicians with home deliveries. When asked to elaborate on this nursing experience Mrs. Pfeiffer humorously recalled one stormy autumn night when she assisted on maternity cases from late evening until dawn. The wind was so strong that keeping the oil lamps lit was her major challenge![119]

The Pensacola Hospital changed its name to Sacred Heart Hospital in 1949. It remained on Twelfth Avenue for almost 50 years. In 1965 it was moved to a new site on Ninth Avenue and continues to operate there at the present time. In 1965 the nursing school was phased out; however, a clinical instruction program for nursing students continues under the sponsorship of Pensacola Junior College.

Among the physicians who came to Pensacola during this era were Walter C. Payne and Herbert Lee Bryans, son of Dr. Robert Lee Bryans.

Dr. W. C. Payne, FMA President and Civic Leader

Dr. Walter C. Payne was born in Luverne, Alabama in 1889 and graduated from the medical school of Tulane University in 1912. He interned at Charity Hospital in New Orleans and came to Pensacola in 1914 to practice medicine. He served in the U. S. Navy during World War I.

Dr. Payne's impressive medical career is familiar to Pensacolians. He served as President of the Escambia County Medical Society and of the FMA in 1949.[120] He was instrumental in organizing the local Blood Bank and headed it for many years. His concerted efforts on behalf of health and civic organizations and Pensacola hospitals continued unceasingly until his death on May 3, 1972. His son, Dr. W. Clifton Payne Jr. practices surgery in Pensacola at the present time.

Dr. Bryans—FMA President

Dr. Herbert Lee Bryans was born in Griffin, Georgia in 1889 and came to Pensacola at an early age. He graduated from the Atlanta College of Physicians and Surgeons (later Emory University School of Medicine) in 1911 and did postgraduate work in Internal Medicine at the New York Post Graduate Medical School.[121] He practiced in Pensacola until 1917 when he was commissioned a First Lieutenant in the U. S. Army Medical Corps. After World War I he accepted a position with the U. S. Veterans Bureau. In 1923 he resigned from government service and resumed private practice in Pensacola. Dr. Bryans served as President of the FMA in 1935 and was chairman of the Florida State Board of Health from 1941 to 1957. Locally he participated in the establishment of the Escambia General Hospital (now University Hospital) and the Escambia

County Health Department. Dr. Bryans died June 8, 1961.

Influenza Epidemic—1918

During World War I the majority of Pensacola's physicians volunteered their services in the military. The impact of the physician shortage in the area was most acute during the autumn of 1918 when the influenza epidemic was most severe.[122]

As the illness spread throughout the city, absenteeism among the telephone company operators and the electric car company employees sharply curtailed these services. Public gatherings were discouraged. Movie theatres, churches and schools closed. Pharmacies had difficulty coping with the monumental demand for drugs and supplies. Relief pharmacists were provided by the Naval Air Station. The Liberty Loan Drive was halted.[122]

Chaos was averted by the efficient coordination of all available manpower by the Pensacola Emergency Relief Committee organized under the auspices of the local Red Cross Chapter. Headquarters were established at 125 South Palafox Street. Pensacolians were advised to direct all requests for assistance to this central office. Calls for physicians were handled. Messengers were available to deliver prescriptions to the sick. Volunteers staffed a motor pool. Food was prepared and delivered to homes where everyone was ill. Volunteers also provided home nursing care.

In describing the aura of tragedy which prevailed during the epidemic, Mrs. E. P. Nickinson stated that W. A. Blount Jr., one of the volunteers of the Emergency Relief Committee, died from the illness he contracted while serving others. One family—mother, father and two young children—moved into the city and a few days later were found dead in their home.

During this time young student aviators lived at the San Carlos Hotel because of the housing shortage at the Naval Air Station. The incidence of the flu among these men was high. Mrs. Nickinson recounts that funeral processions were reportedly requested not to go by the San Carlos Hotel because of the depressing effect they had on the student aviators.

Mrs. Marguerite Skotsky Pfeiffer was one of the few student nurses at the Pensacola Hospital who remained well during the epidemic. At one point only six nurses were available to care for 101 hospitalized patients. Mrs. Pfeiffer sadly recalls the number of pregnant patients who died from the illness. Therapeutic measures such as oxygen and intravenous fluids were not available.[119]

Accounts of misfortune and heroic deeds abound. One of the saddest incidents was the death of Dr. J. A. Wells, a 30-year-old Panama City physician. Dr. Wells had come to Pensacola to assist overworked physicians during the epidemic, only to become a fatality himself shortly before the epidemic subsided.[122]

Bubonic Plague

In June 1920 Pensacola physicians were confronted with bubonic plague, a public health problem that never before had affected the city. On June 12, Peter Gardina, a patient of Dr. Herbert L. Bryans, died from the illness.[123]

Under the direction of Dr. S. R. Mallory Kennedy, U.S.P.H.S. and Major Ralph N. Greene, State Health Officer, immediate measures were taken to protect Pensacola against this disease transmitted by rats and fleas.

Plague is a disease caused by a gram-negative bacillus, Pasteurella pestis. It is primarily a disease of rats and wild rodents with man serving only as an accidental host. Bubonic plague is the most common form. Infected fleas usually bite man on the lower limbs and the bacilli rapidly spread to the lymphatics of the groin. The enlarged lymph nodes are known as buboes; hence the name "bubonic." Death occurs when the plague bacilli are not confined to the local lymph nodes, and the disease becomes generalized.[124] Between 1900 and 1944, 504 cases were reported in the United States and 63% of the infected patients died of the disease.[124]

Pensacolians were urged to catch rats and to immerse them in kerosene to prevent the escape of any fleas that might be present. The rats were turned over to the state laboratory at Palafox and Cervantes Streets for examination. Warehouse and wharf owners constructed floats to moor vessels six feet away from the docks. All outgoing ships and freight cars were fumigated.

On June 18, 1920, the USPHS Laboratory car, under the direction of Dr. R. R. Spencer, and a complement of inspectors, fumigating experts and rat catchers came to Pensacola from Mobile to assume responsibility for controlling the spread of the disease. The State of Florida appropriated $40,000 to help defray the cost of the extermination program. In early July the city of Pensacola passed a strict rat proofing ordinance which directed Pensacolians to cover garbage, to clear

weeds from their property, and to raise lumber piles to prevent rats from nesting underneath.

By August 1, 1920, 20 of the 8,800 collected rats were found to be infected. By plotting the locations of the infected rats, Dr. Spencer concluded that the infection had been carried in by rail and not by ship.

According to Dr. S. R. Mallory Kennedy, there were seven deaths among the ten cases of bubonic plague in Pensacola. The city had spent over $383,000 for rat proofing before the last case was diagnosed on August 31, 1920. Rat proofing measures were maintained until August 15, 1921.[125]

Medical Society Activity

In 1917 Dr. Pierpont reported to the FMA that the Escambia County Medical Society, "one of the livest wires in the State Association," held well attended meetings at which scientific papers were regularly read.[126] Many of these were published in the JFMA.

Dr. Kennedy—FMA President

In 1921, the FMA held its annual meeting in Pensacola. Dr. S. R. Mallory Kennedy was elected President.[127]

Dr. Pierpont—Medical Legislation

In 1914 Dr. J. Harris Pierpont, a staunch proponent of legislation to create a single State Board of Medical Examiners, spoke to the members of the FMA at their annual meeting in Orlando. In his address he reviewed the efforts of the Committee on Legislation and Public Policy to successfully initiate legislation to modernize Florida's medical laws. The irregular schools of medicine, including the Christian Scientists, he pointed out, sent representatives to Tallahassee to oppose medical legislation supported by the FMA.

Dr. Pierpont urged local medical societies to accept for membership "every reputable white and legally registered physician who is practicing, or who will agree to practice non-sectarian medicine."[128] He further argued, "I know of no more effectual plan to disarm an enemy than by sincere friendship, and the adoption of a common cause for mutual benefit. Then why not abandon the idea of exclusiveness, and not only invite members of other schools who are eligible to membership, but, to use a common phrase, 'go after' them and impel them to unite with the county society."[128]

A united medical profession, he contended, would be a more effective force in the interest of medical legislation. "All reform measures have exacted personal sacrifices on the part of the devotees of a cause, so why should not a doctor be willing to wield his influence, devote his time, and spend his money for the advancement and elevation of his profession?"[128] He encouraged participation in local politics by his fellow physicians. Dr. Pierpont's concluding remarks cautioned, "It therefore only remains for us to determine whether we will 'go after' what we so much need and desire, or continue the old drifting policy which has so many times wrecked our efforts for modern medical legislation."[128]

Seven years later, in 1921, the goals of physicians such as Dr. Pierpont were realized when the Florida legislature enacted a measure creating a single State Board of Medical Examiners.[129]

Conclusion

During this 50 year period, 1873-1923, the medical profile of Pensacola experienced vast changes. Individual physician activity in rendering health care evolved into a more cooperative effort as evidenced by the establishment of a large modern hospital, thus replacing smaller proprietary facilities. A small county medical society matured and joined forces with the FMA in securing state legislation in establishing a medical practice and licensure act. As the medical profession became scientifically oriented, the public health concerns changed dramatically. Yellow fever faded into historical oblivion. Bubonic plague yielded to modern concepts of quarantine and pest control. Pensacola, a small Gulf Coast settlement previously nestled around the waterfront, grew into a populous city with developing suburbs and diversified economic interests.

The theme of rebirth, change and growth that is woven into this 50 year post Civil War period reflects the comment of Gert H. Brieger, a medical historian, "History abounds in recurring themes."[130]

References are available upon request from the authors.

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Leon County Medical History

I. Barnett Harrison, M.D.

It was a long way from St. Augustine to Pensacola in 1821 when Spain ceded Florida to the United States. So Governor Duval, Andrew Jackson's successor, decided that the territorial capital should be located halfway between. Demonstrating wisdom, he selected a physician to help make the choice. Dr. William H. Simmons of St. Augustine and John Williams, a Pensacola lawyer, were commissioned to decide on the location. After difficult journeys, with much hardship and delay, the two met at Fort St. Marks on the panhandle coast in 1823. One version has it that Williams was fed up with the expedition and ready to proclaim St. Marks the capital, but Dr. Simmons advised against this site, pointing out that "the miasmas of its marshes might mean epidemic and death."[1] Accordingly, a higher site was chosen inland at the Indian village of Tallahassee. Since 1824 this area has been judiciously retained as the capital of the territory and later the state in spite of legislative debate continuing into the late 20th century.

First Medical Society and Fee Schedules (1826-1833)

In spite of Dr. Simmons' decision, Tallahassee had a bad health reputation during the early years. But for a town its size, there was an abundance of doctors. In 1826, with a population of about 700, there were at least seven practicing physicians, or a ratio of 1:100.[2] And by 1860, with a population of about 3,000, there were 14 physicians, or a ratio of 1:200 (compared with the current ratio of about 1:2000 engaged in primary care).

It did not take long for the doctors to become organized. The first evidence of a capital medical society is in 1826. One of the accomplishments of this group was the establishment of a fee schedule on a relative value scale, which was published in The Florida Intelligencer.[3] There may be more reliable information about UCR fees in 1826 than the computers have been able to provide for 1973. These services and charges were underwritten by the capital's first physicians: Drs. A. W. Coleman, C. A. Watkins, Edmund Tucker, R. S. R. Wilson, and Lewis Willis. Dr. Willis was the great-grandnephew of George Washington. His sister was married to Prince Murat, nephew of Napoleon Bonaparte. Dr. George W. Call, brother of territorial governor Richard Keith Call, and Dr. Thomas Orr were also practicing physicians at that time, but were apparently nonparticipants in the UCR arrangement.

There is evidence of revision of the "relative value schedule" in 1833. A notice in the February 24, 1833 issue of The Floridian is quoted, as follows:

> With a view to harmony amongst the profession to remove discrepancy of charge and to let our friends fully understand the terms under which they employ, vis: We the physicians of Tallahassee in convention met, do resolve unanimously upon the following fee bill.
>
> The medical fee bill of Tallahassee will be, as follows:

1.	Mileage by day $.50, by night	$ 1.00
2.	Attendance all day	$10.00
3.	Attendance all night	$20.00
4.	Prescription in single case	$ 1.00
5.	Prescription for 3 or more at the same house, $.50 for each patient	
6.	Box of medicine	$ 1.00
7.	Six or twelve powders	$ 1.00
8.	Bleeding	$ 1.00
9.	Drawing teeth	$ 1.00
10.	Leeching	$ 4.00
11.	Laying open abscess	$ 3.00
12.	Delivery of woman in natural labor	$25.00
13.	Amputation, leg	$25.00
14.	Amputation, finger	$10.00
15.	Amputation, thigh	$30.00
16.	Setting fracture of arm or leg	$20.00
17.	Reducing dislocated hip joint	$30.00

> All others too numerous to be here inserted, in the same proportions.
>
> We, the subscribers, would beg leave to state to the citizens of Tallahassee, and the public, that in pursuance of resolutions entered into by us, upon the first of January, 1833, there will in future be no stipulated bargain or engagement with any favor, for the professional services therein rendered by either of us.

This notice was signed by Drs. John A. Craig, Lewis Willis, John B. Taylor, J. H. Randolph, and John McLemore.

Subsequent issues of The Floridian reflect considerable controversy in letters to the editor about these fees. Responses by physicians assured the public that the published charges were maximum guidelines and that there would be no neglect of those who were unable to pay.

First Board of Medical Examiners (1828-1845)

In the Territory of Florida an act was passed in 1828 providing for a medical board to hold an examination yearly for prospective physicians and for the protection of the public.[4] Members of the

original board from Tallahassee included Drs. Thomas Monroe, Lewis Willis, and William Price. The act, however, was repealed three years later. But when Florida became a state in 1845, the board was reestablished. Five of the ten doctors comprising the first permanent state board were Tallahasseans.[2] They were Drs. J. H. Randolph, John Bond, George Call, John L. Call, B. J. Scriven, and John L. Crawford. Although the board was granted licensing authority, there was a flaw in the act providing "that nothing herein shall prevent any physician in the state from proceeding in the manner now directed by law for procuring a license to practice medicine."[5] The usual manner was by filing with the county clerk a diploma from a medical college, and a certificate signed by two practicing physicians of the territory. It was much later that the board was given teeth.

Dr. James H. Randolph, one of the members of the first state board was the son of Thomas Randolph, a wealthy planter. He was a member of the first state legislature in 1845 and mayor of Tallahassee in 1876. He became superintendent of Florida State Hospital in Chattahoochee in 1881; was president of the Leon County Medical Society in 1878, and was a charter member of the Florida Medical Association. His son, Arthur L. Randolph, a Tallahassee physician, was also a charter member of FMA and treasurer in 1877.

Dr. John L. Crawford, another original board member, was a member of one of Georgia's most distinguished families. He served in the General Assembly of Florida before the Civil War and in several legislative sessions during reconstruction. He was appointed Secretary of State by Governor Bloxham in 1881, in which office he served until his death in 1902.

Civil War and Reconstruction (1861-1876)

We are told by Cash that "no profession showed up better in patriotic service during the Civil War than that of physicians."[6] Hospitals were established in Tallahassee, Lake City, Gainesville, and Madison. The City Hotel of Tallahassee, across from the Capitol, was converted into a hospital. The Confederate War Department sent Dr. Morrell to take charge jointly with Dr. J. H. Randolph. It was reported to be full at the time of the surrender. Near the close of the war at the Battle of Natural Bridge 15 miles south of Tallahassee, doctors hurried there in their buggies. This minor southern victory for an already lost cause did result in Florida's capital being the only one in the Confederacy which did not fall into Union hands.

Among Tallahassee area doctors serving with distinction during the war were Drs. John Bond, Cary Gamble, J. H. Randolph, William Robertson, D. M. Carn, J. W. Eppes, R. B. Burroughs, Richard W. Gardner, and T. M. Palmer.

One cannot know the history of medicine in the capital region without knowing the history of the Palmer family.[7] Although prominent members have practiced elsewhere, there are three men of successive generations of great importance to this region. All three have been outstanding practicing physicians, leaders in the state, and presidents of the FMA. They are Thomas Martin Palmer (1821-1895); his nephew, Henry Edwards Palmer (1866-1944); and Henry's son, George Saxon Palmer (1917—).

Young Tom came to Monticello in Jefferson County in 1829, eight years old and eight years after Florida became a United States territory. After graduating from the University of Maryland, he returned to Monticello where he spent his life in practice except for the Civil War. He served in the Constitutional Convention of 1861, which passed the Ordinance of Secession. During the war he served as a surgeon in the Confederate Army, chiefly in Virginia near Richmond. It was Dr. Tom who discovered Confederate officers looking over a site for headquarters that he had already chosen for a field hospital. Approaching the leader, he urged him to seek another location for battle purposes so that he could retain the shaded area for the wounded. Complying promptly with his request, the officers galloped away to another site. On the next day, Dr. Palmer was introduced to that leader, General Robert E. Lee. Undaunted even by the presence of Lee, it is not surprising that Dr. Tom later during stormy reconstruction caused a Republican governor to yield to his demand, in a face to face confrontation, for Democratic representation in Jefferson County government.

Dr. Tom Palmer was president of the FMA in 1876.

Dr. Cary Brechinredge Gamble practiced with Dr. James Randolph until the Civil War. He served under Bragg and was captured by Grant at Shiloh while caring for the wounded.

Dr. Edward Bradford, owner of a large plantation, volunteered his services during the war but the Secretary of War requested him to remain at home and furnish supplies to the army.[4] He

married Martha Branch, daughter of Governor Branch of Florida. After the war his daughter married Nicholas Eppes, the great-grandson of Thomas Jefferson.

Dr. R. B. Burroughs was the grandson of the Attorney General in Andrew Jackson's administration.[8] He practiced in Tallahassee from 1856 until the Civil War. He was decorated for heroism in the Battle of Atlanta. Later he fought in the Battle of Olustee. After the war, he moved to Jacksonville, was a charter member of the FMA and its president in 1897.

George Troup Maxwell[9] practiced in Tallahassee from 1848 until 1857. During the Civil War he was captured while serving under Bragg at the Battle of Mission Ridge, and was imprisoned on Johnson's Island until 1865. He returned to Jacksonville after the war, where he perfected a laryngoscope in 1869. He is said to have been the first American to see vocal cords in a living subject. As City Health Officer he is quoted as saying in 1869 that he had "never seen a building so obnoxious as (the) Duval County Jail."[10] Dr. Maxwell was a member of the welcoming committee to greet General Lee in Jacksonville in 1870 on Lee's trip to Florida for his failing health.

Founding of FMA (1874)

At the founding meeting of the FMA in Dr. A. S. Baldwin's office in Jacksonville, Leon County was represented by Drs. George W. Betton and R. B. Burroughs.[10] Dr. Betton was elected temporary chairman at that meeting and was subsequently president in 1881. Other charter members from the Leon Society included Drs. J. M. Carn, A. L. Randolph, J. H. Randolph, and Richard Gardner.

Dr. Betton lived and practiced in Tallahassee for many years, having arrived at the age of four from Virginia. He was responsible for the education of the first black physician in Leon County.[1] William Gunn (1864-1922) drove a horse and buggy for Dr. Betton. When he expressed a burning desire to become a doctor, Dr. Betton provided for his education at Meharry in Nashville. Dr. Gunn then practiced among black and white in the counties of Leon, Washington, Franklin and Gadsden for the rest of his life.

Another FMA charter member was Dr. Julius M. Carn of Centerville (near Tallahassee). He is listed as being the corresponding secretary of the Leon County Medical Society in 1878.

Dr. J. H. Randolph and his son, Dr. A. L. Randolph, have been discussed earlier.

The FMA launched in 1874 by representation from six counties (Duval, Leon, Columbia, St. Johns, Marion and Nassau), unlike the fledgling attempt at Quincy in the 1840's, was destined to become and remain a strong organization.

After the Creation (1874-1974)

It was Dr. George Betton whom Dr. Henry E. Palmer joined in practice in Tallahassee in 1892.[7] Dr. Palmer was deeply interested in organized medicine and contributed significantly to the FMA during its early years. He was its president in 1909, member of the State Board of Health, and of the State Board of Medical Examiners. He was the father of Dr. T. M. Palmer of Jacksonville, Dr. George S. Palmer of Tallahassee and Dr. Martin Palmer of Anchorage. Dr. George Palmer was president of FMA in 1966.

In the past hundred years there have been seven FMA Presidents from the capital area. In addition to the three Palmers, there were Dr. George Betton (1881), Dr. R. B. Burroughs (1897), Dr. F. C. Moor (1914), and Dr. J. C. Davis (1930).

The 20th century history of the Leon County Society will be the subject of a subsequent report. Although there are gaps in the available records at this time, it appears that an organization has been in existence for 150 years, interrupted only by the Civil War. During the 20th century Leon County has had affiliation with other counties in its official FMA representation. The Second District Medical Society became the Leon-Gadsden-Liberty-Wakulla-Jefferson (or Five County Society) in the 1930's. This was changed to the Tri-County Society (Leon-Wakulla-Jefferson) in 1963, and in 1973 the name was changed to Capital Medical Society.

Although the so-called "Big Bend" area has been dwarfed by massive population growth in the southern part of the state in this century, the capital has continued to provide leadership in the state. Dr. Francis Holland is the senior AMA delegate. And returning again to the significant Palmer family, Dr. George Palmer is currently the Executive Director of the State Board of Medical Examiners.

As a new century begins for the FMA, the Capital Medical Society is thriving after reorganization under the energetic leadership of Drs.

Edward G. Haskell and Jack W. MacDonald. Being in a strategic location at the capital site, its members are likely to continue to have an important and close relationship with governmental leaders, as in the past.

As one traces the path of the local society over a period of 15 decades, and later the state association for a century, it seems clear that organizational activities have consistently focused on the goal of quality medical care and better health for the people of Florida. Some of these include: (1) a lengthy struggle to develop a State Board of Medical Examiners with the necessary authority for maintaining standards and discipline; (2) a determined stance for over 100 years, and still continuing, to eliminate cultists, quacks, and others with incompetent credentials in the healing professions; (3) difficult legislative battle to establish a strong State Board of Health with adequate county health departments to provide extremely important functions in preventive medicine; (4) a cooperative effort to establish in Florida a nonprofit insurance company to help people cover their medical expenses, growing into the now gigantic Blue Shield of Florida.

Although reaching these goals has been met with controversy, it appears in the context of history, that organized medicine in the capital area and in the state has in this regard placed the public interest above self-interest. And in so doing, these distinguished medical pioneers of our past have charted a course worthy for the profession to follow in the future.

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▶ Dr. Harrison, 1433 Miccosukee Road, Tallahassee 32303.

History of Medicine Along "Fishermen's Broadway"

Mary Turk

With sad reflection and regret, "Old Timers" recall the days of the 1880's when the fresh waters of Lake Worth were so clear that objects could be seen lying on the sandy bottom and the fishing so good it was called "Fishermen's Broadway." This beautiful lake, 22 miles parallel to and never more than a half mile from the ocean, bordered with fertile land, a wilderness of tropical growth and wild fruit, was a great attraction for the first settlers.

Arriving in May 1882, Dr. Richard Buckley Potter was the first physician to serve a small colony of people. He shared their primitive manner of living, walked the beaches to make his calls, later obtained a boat and aided by a midwife became a familiar sight along "Fishermen's Broadway." Dr. Potter spent most of his lifetime of practice without a hospital or modern facilities and until his death in 1909 he was listed as a charter member and vice president (1903) of the Dade County Medical Association. This area was a part of Dade County at that time.

Dr. Henry C. Hood was the second physician and until 1898 he and Dr. Potter were the only ones to practice in the fast growing community. Dr. Hood, who died in 1919, was very active in organizing the first hospital and first county medical society.

Emergency Hospital

Extension of the railroad during the 1890's started a real boom. New business establishments opened and population increased considerably. At the turn of the century this rapid growth created the need for a place to care for emergencies and to house the sick. The first attempt was a city project that failed due to a poor location in swampland. Dr. and Mrs. Leon Ashley Peek revived the project in 1910. Their keen interest and untiring efforts were responsible for the building of a five bedroom cottage known as "Emergency Hospital." It opened in 1914. Everyone took an interest and all business places closed to attend the benefit baseball games which netted a neat sum. In less than three years the cottage became overcrowded and understaffed. Planning for a larger hospital began and in 1920 Good Samaritan with 35 beds opened at its present location on Flagler Drive, along "Fishermen's Broadway."

Palm Beach County Medical Society

The organizational meeting was held on September 20, 1919 at the office of Dr. L. A. Peek with Dr. T. D. Gunter serving as temporary chairman and Dr. C. M. Conkling as temporary secretary.

Present were Drs. Roy O. Cooley, C. M. Conkling, E. A. Crow, T. D. Gunter, H. P. Gerlach, H. C. Hood, C. M. Merrill, Alice R. Miller, L. A. Peek, O. B. Van Epp, Wm. E. Van Landingham, and F. B. Eurit from Stuart. Not present but listed as a charter member was Dr. J. R. Cason from Delray. They elected Dr. Merrill

Mrs. Turk, whose husband, Dr. A. Scott Turk, practices at Lake Worth, is State and County Chairman of Research and Romance of Medicine, Woman's Auxiliary to the Palm Beach County Medical Society.

Fig. 1.—First "Emergency Hospital."

president, Dr. Hood vice president, and Dr. Gunter secretary and treasurer. Annual dues were set at $5.

Other business included the adoption of a fee schedule: West Palm Beach calls $2, out-of-town calls $3, night calls (11 to 6) $4, obstetrical (normal) $30, consultation $10, urine examination $2, anaesthesias $5 to $25, and gonorrhea and syphilis 1st treatment $5.

Within its first year members of the Society mourned the death of Dr. Hood. They held meetings in different homes and offices, enjoying the opportunity to get together and discuss their cases. Some of the first papers presented included "Intestinal Parasites" by Dr. Conkling; "Early Application of Forceps in Labor" by Dr. Cason, and "Fibroid Tumors" by Dr. Peek.

Flagler's Dream

Henry Flagler's dream of establishing a commercial city on the west side of the lake and a fashionable resort on the east side along the ocean became a reality. Business magnates and millionaires changed the small country town into a fast growing city and "Fishermen's Broadway" became an inland waterway for big yachts.

The medical society's membership reached 53 during the 1920's.

After 50 years service Dr. Van Landingham recorded this message: "Little does the doctor of today realize how fortunate he is to walk into a complete workshop furnished him in modern hospitals, with miracle drugs to aid him. Consultants in every line of practice, and laboratories to assist in diagnosis, rather than his having to depend on clinical knowledge or judgment. Unless a doctor has been fortunate enough to have had a glimpse of country practice before moving into an urban area, it must be admitted that he really has lost some of the experiences that were commonplace to the doctor of yesteryear and he is also deprived of that nostalgic feeling that we now enjoy for having lived in that age of hardship, sharing with each family the joy of a new born baby's cry, the sadness and tears of the loss of a loved one, and the wishful thinking of what we might have accomplished had we not been born thirty years too soon."

Added to the trials and growing pains of the 1920's was the hurricane of 1928. Most buildings, doctors' offices and homes in West Palm Beach were damaged or destroyed. Kelsey City (Lake Park) was wiped out, and 2,000 residents of the southeastern shore of Lake Okeechobee drowned in a 12 foot tidal wave. Doctors worked throughout the night assisted by their wives and the women of the community. The disaster was charted as the third worst in the nation.

Pioneer Doctors

Pioneer physicians of the 1920's still observing with considerable interest the results of activities they set in motion include A. H. King (Delray), Wm. Y. Sayad, A. L. Rowe (Lake Worth), L. M. Rozier, N. M. Weems (Boynton), Lloyd J. Netto, Gaylord Lewis, James L. Carlisle (keeps regular office hours at age 86 and says, "I'll probably die with my boots on, I'd rust with nothing to do."), and W. M. Blair who kept office hours until he reached age 83 then retired to his home from which he takes care of a few patients.

Dr. Weems, Boynton Beach's first physician, arrived in a Model T Ford almost 50 years ago and stayed to watch the town grow from 1,500 people to more than 27,000. He was the only doctor for 25 years and has delivered more than 7,500 babies.

Fig. 3.—Kitchen table surgery.

Dr. Weems was born in Lawrenceville, Ala., May 3, 1898, and was graduated from Emory University in 1924. During the struggle to start a practice, the 1928 hurricane hit and his office was demolished. He spent three months with the Red Cross aiding victims. After that came the economic disaster of 1929. Many people left for good but he stayed and in 1935 opened his first clinic with an assistant. World War II drained the county of doctors soon after. "Of 53, 18 were called. This left 35 doctors to serve 80,000 people. Today there are more than 400 doctors to serve 400,000 people."

From 1957 until his retirement in 1962 Dr. Weems shared his practice with his son. His interest in horticulture led him to supply many plants, trees and shrubs to churches, schools and hospitals. He was honored by the Boynton Beach City Council, county officials and many friends in a ceremony dedicating the new police complex in his name.

Other Pioneer Doctors

Dr. Wm. E. Van Landingham

William Ernest Van Landingham was born in Boston, Georgia, August 7, 1879, the oldest of 11 children. His father, engaged in the lumber business, moved the family to Titusville in 1887. This was the terminus of the railroad and from here lumber was transferred to boats. Ernest and his brother, Sam, shared the duties of this pioneering business by sailing the boats along the Indian River delivering the lumber.

Ernest started work at an early age to finance his education. He entered Baltimore Medical College, and during his senior year married Aleph Mims. That year, 1905, his family moved to Miami and he and his wife decided to join them and start practice there. Miami had three doctors and not enough people to support another one so in six weeks Dr. Van Landingham, receiving a call from Ft. Pierce where there was no doctor, moved there. His three sons were born in Ft. Pierce.

In 1918 Dr. Van Landingham moved his family and practice to West Palm Beach. He was a charter member of the Palm Beach County Medical Society, served as secretary five years and as president in 1924. He was also superintendent of the hospital in its infancy.

His practice was that of a typical country doctor: making calls by horse and buggy, bicycle, train and boat. On one night call he returned to the dock and stepped off into waist deep water; the tide had carried his boat out. Another memorable call was an obstetrical case in Ft. Pierce where he had spent the night delivering a boy. Returning home he was in some doubt as to the fee but finally sent a bill for $25. The boy grew up and became an artist. One day Dr. Van Landingham received a beautiful painting with a note from the artist stating he felt he was worth more than $25.

Dr. Van Landingham served as City Health Officer for 25 years and in 1945 assumed the duties of public health and welfare. The Palm Beach County Home named its new addition in his honor, "Van Landingham Wing."

Fig. 2.—Good Samaritan Hospital. Original completed in May 1920.

His long years of service devoted to varied duties ended at the age of 91. "He counted it a thrilling lifetime that allowed him to see his boyhood town, where he once traveled by boat and wagon, develop into a concentration of scientists and technicians who can rocket a man to the moon."

Dr. Jay Allen Powell

Dr. Jay Allen Powell, outstanding physician and civic leader, was born in Dothan, Ala., October 2, 1893. He attended Tulane University and was graduated from the University of Oklahoma School of Medicine in 1918. Coming to West Palm Beach in 1919, he served as president of the Palm Beach County Medical Society for two years and taught surgery at the Good Samaritan School of Nursing. He became a life member of the Florida Medical Association and the American Medical Association and a Fellow of the Southeastern Surgical Congress.

Dr. Powell was recognized for his work in the Kiwanis Club. A charter and life member, he started the Kiwanis Surgical Clinic for underprivileged children, operated on more than 10,000 children and was awarded a pin for 25 years service. Kiwanis International presented him the Legion of Honor plaque in recognition for service and proclaimed him its most outstanding member.

Dr. Powell's love for his fellowman was manifested in his service to the needy through the Salvation Army. He was a member of the advisory board of the Empty Stocking Fund. He was a charter member of Mahi Temple Shrine, Miami, and a thirty-second degree Mason. His military service was with the enlisted reserve corps, first enlistment period, University of Oklahoma, December 14, 1917.

He married Emily Gertrude Gill of Petersburg, Va.

Dr. J. R. Cason

Dr. John Robert Cason Jr. was graduated from the University of Arkansas School of Medicine and served an internship at St. Luke's Hospital in Little Rock. He moved to Delray Beach in 1905 at age 24 becoming the first and only doctor to serve the sparsely settled section from Palm Beach to Pompano Beach until 1920.

Arriving in Delray only nine years after the first settlers, he faced lack of facilities and unsanitary conditions. There was no electricity, telephones were scarce, and few roads led to the deeply rutted sand trails going to the widely scattered farms. Calls of any distance were made by train, necessitating that he be met by someone with horse and buggy. One fateful night Dr. Cason was called to Deerfield so he jumped aboard an open boxcar which happened to be occupied by a tramp who, fearing detection, attacked him. Fortunately the trainmen saw him fall from the car and stopped the train. For a time there was grave concern that he would survive the injuries.

A two-room building on Atlantic Avenue served as office and drugstore where Dr. Cason filled his prescriptions. In 1912 he persuaded his brother-in-law, Luther Love, to come to Delray; so Love's Drug Store was established and is still popular.

An epidemic of diphtheria swept the area and Dr. Cason's efforts to treat and quarantine the people were resented by some. He staged a campaign to clean up outhouses and administer vaccines in an effort to eradicate typhoid.

Early residents of Delray had a long fight for economic survival and Dr. Cason's practice was not a lucrative one but his reward was in the fact that he was doing what he wanted to do—healing the sick. A compensating factor was that his grateful and perceptive patients knew how much harder their lives would be were it not for "The Doctor."

Past to Present

Palm Beach County now has 12 hospitals and the Palm Beach County Medical Society of 1973 has a membership of 510 physicians.

Good Samaritan Hospital with 35 beds in 1920 gradually increased its bed capacity to 122 in 1940. In 1948 the Board of Governors embarked upon a long-term building program, a step by step architectural plan. In 1961 the south wing which provides the most modern rooms for patients was begun. An intensive care unit was completed and an auditorium with seating capacity of 278.

Currently the hospital is completing an $11 million program which brings bed capacity to 350. Included in this construction also are buildings housing departments of nuclear medicine and radiation therapy. A four-story parking garage with helicopter pad on the roof has been completed.

Acknowledgment

The author wishes to acknowledge the assistance of Sam Quincy, Dr. Russell D. D. Hoover, Mrs. Joan H. Fox, Dr Charles M. Harris, and Dr. and Mrs. Richard Irwin.

▶ Mrs. Turk, 818 Golfview Road, Lake Worth 33460.

MEETINGS

Approved by FMA Committee on Continuing Education

JANUARY

14-19 Miami Winter Symposia (Biochemistry) Sheraton Four Ambassadors Hotel, Miami*

16-19 Eighth Annual Postgraduate Seminar in Surgery Eden Roc Hotel, Miami Beach*

21-25 Hematology 1974—Presented by the American College of Physicians in cooperation with the Department of Medicine
Sheraton Four Ambassadors Hotel, Miami*

23-27 Pediatric and Adult Urology
Playboy Plaza Hotel, Miami Beach*

24-25 Noninvasive Cardiovascular Evaluation, 1974, Flagler Inn, Gainesville**

24-26 Infectious Diseases—1974: Treatment and Prevention, Eden Roc Hotel, Miami Beach. For information: Marvin L. Meitus, M.D., 1680 Meridian Avenue, Miami Beach 33139.

24-27 Postgraduate Seminar in Pediatric and Adult Urology, Playboy Plaza, Miami Beach. For information: Michael P. Small, M.D., 1200 N.W. 10th Avenue, Miami 33136.

28-31 Postgraduate Seminar in Neurology
Sheraton Four Ambassadors Hotel, Miami*

31-Feb. 3 Nineteenth Central Florida Medical Meeting presented by Orange County Medical Society and Seminars and Symposia, Contemporary Plaza Hotel, Disney World. For information: Seminars & Symposia, Inc., Box 1537, Richmond, Va. 23212.

FEBRUARY

2- 6 Postgraduate Course in Clinical Allergy
Sonesta Beach Hotel, Key Biscayne*

4- 9 Florida Midwinter Seminar in Ophthalmology and Otolaryngology
Americana Hotel, Miami Beach*

4- 9 Courses of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

17-22 Internal Medicine 1974
Sheraton Four Ambassadors Hotel, Miami*

22-24 Pediatric Dermatology Seminar, Fontainebleau Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

28 Treatment of Serious Infections, Sheraton Four Ambassadors Hotel, Miami*

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*For Information: Contact the Division of Continuing Education, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32601.

MARCH

7-10 Skin 1974: Modern Management of Common Skin Disorders—Seminars for the Family Physician
Playboy Plaza Hotel, Miami Beach*

13-15 Fifth Annual Topics in Internal Medicine Hilton Hotel, Gainesville**

13-16 Sixth Teaching Conference in Clinical Cardiology Sheraton Four Ambassadors Hotel, Miami*

13-17 Thyroid and Endocrine System Investigations With Radionuclides, Playboy Plaza Hotel, Miami Beach*

26-30 Radiology in Medical and Surgical Emergencies. Playboy Plaza Hotel, Miami Beach*

APRIL

3- 5 "Clinical Nephrology and Heart Disease II," Eden Roc Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

8- 9 Hypertension, Sheraton Four Ambassadors Hotel, Miami*

8-12 Ophthalmic Plastic and Corneal Surgery
Doral Hotel, Miami Beach*

19-20 Practical Optics and Refraction, J. H. Miller Health Center, Gainesville**

22-27 Courses of Instruction in Coronary Care for the Practicing Physician, University of Miami School of Medicine, Miami 33152*

25-27 Urology: Selected Topics for the Practitioner, Hilton Hotel, Gainesville**

MAY

2- 4 Master Approach to Cardiac Emergencies
Contemporary Hotel, Disney World, Orlando*

3- 4 The Management of the Critically Ill Patient, Hilton Hotel, Gainesville**

4 Intensive Care Symposium (Department of Surgery, University of Miami, in cooperation with the Department of Anesthesiology, University of Florida College of Medicine)
University of Florida, Gainesville*

9-11 Clinical Care of Bone Tumors, University of Florida, Gainesville**

9-12 Microneurosurgery, Innisbrook Resort & Gulf Club, Tarpon Springs**

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Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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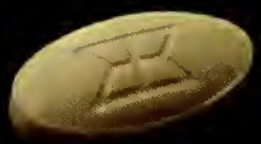

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Once-a-day dosage.

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AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased by Increments of	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	monthly 1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	monthly 0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac Patients	0.5-1.0 mg.	monthly 1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease: history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
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Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
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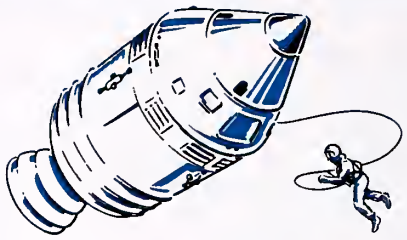

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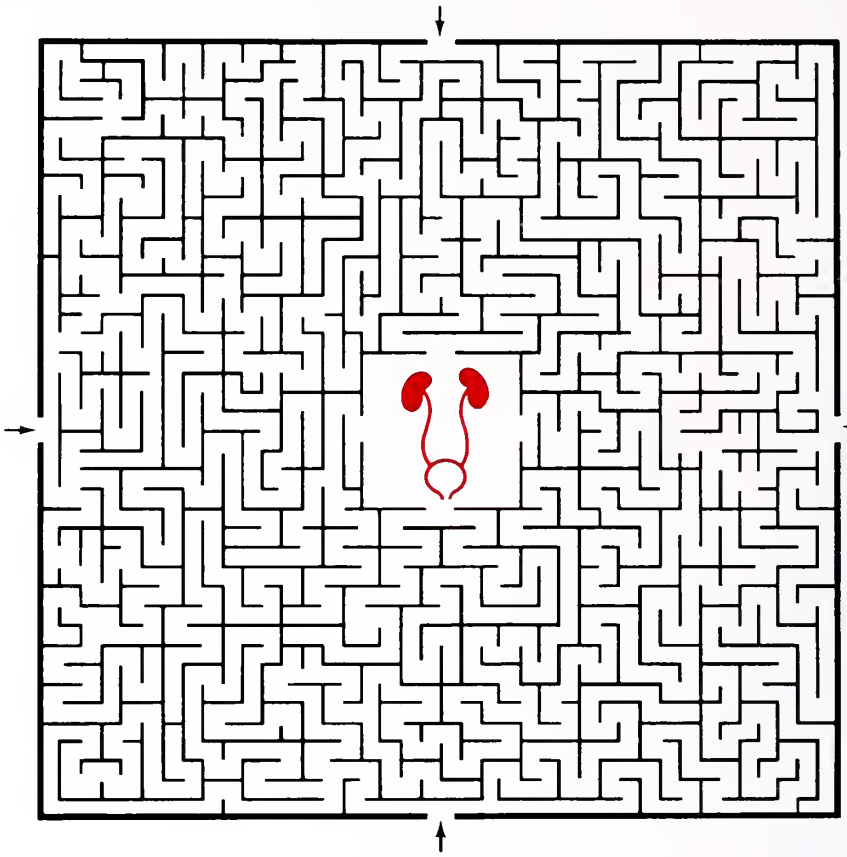
Basics in the treatment of urinary tract infection

Short-term therapy is no shortcut



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The case for adequate length of therapy

In the insidious, common and often stubborn urinary tract infections, duration of therapy is not standardized. Because renal damage in many patients is believed to result from repeated urinary tract infections in childhood, one pediatrician has stated that a rational approach to treatment includes more than a perfunctory prescription of an antibacterial agent.[1]

The first 48 hours and after...

To ensure adequate therapy, one expert[2] proceeds as follows: an initial culture and one after 48 hours. If the antibacterial used has been effective, the urine will be clear of pathogens after 24 to 48 hours. However, urine should be recultured and any persistence of original pathogens indicates that another drug be used. On the other hand, if urine is found to be sterile, the same drug is continued for two weeks. Then urine is recultured starting a week after the last drug dose, and cultures are continued monthly for three months, then every three months for a year, and finally, every four months for several years.[2]

Another authority[3] notes that initial short-term therapy without careful follow-up can lead to trouble, as reflected by the high relapse rate. He treats an initial urinary tract infection with a sulfa drug after taking a urine culture. If *Escherichia coli* is found—and it is in 70 to 80 per cent of cases—he continues full dosage for 21 days. Five to 10 days after cessation of therapy, he recultures and takes a colony count. If urine is sterile, he recultures at three and six months.

Measurement of success

For success in the treatment of urinary tract infecti the urine must be kept free of bacteria for prolonged per ods until the focus of infection in the tissue has been era cated.[3] This may take months or years when the infectio is chronic or persistent. Criteria for successful therapy w a drug are regarded as absence of symptoms and absenc of pyuria and bacteriuria.[3] One authority defines signific bacteriuria as a count of at least 100,000/ml of the sam organism in two consecutive clean-voided urine samples

The nature of the infection and the length of therapy

Long-term follow-up is essential, a clinician who treats recurrent infections for one to two years points ou Persistent, symptomless bacteriuria usually calls for urc logic procedures to find the site of infection, because an underlying abnormality predisposing to urinary tract infe tion must be detected and corrected—otherwise therap futile.[5] Upper urinary tract infection generally requires longer therapy than infection of the lower urinary tract.

In acute, simple, first infections of a symptomatic type, the pathogens are nearly always *E. coli* or *Proteus mirabilis*.[5]

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Gantanol® (sulfamethoxazole) is effective against ·t only susceptible strains of *E. coli* and *Proteus mirabilis* ıt also of *Klebsiella-Aerobacter, Staphylococcus aureus* ·d, less frequently, *Proteus vulgaris*—pathogens apt to be und in the mixed bacterial flora of recurrent and chronic stitis and/or pyelonephritis.

·ompt antibacterial blood/urine levels

After the initial 2-Gm adult dose, therapeutic ɔod/urine levels are usually reached in from 2 to 3 urs, then maintained with either of the two dosage ·ms of Gantanol—tablets or suspension. And, Gantanol ·.*d.* dosage means up to 12 hours of antibacterial tivity, obviating the patient's having to disturb his sleep take medication. More severe infections may require *d.* dosage.

lso effective in certain nonobstructed ıronic and recurrent urinary tract infections

Nonobstructed chronic and recurrent cystitis or elonephritis develops more commonly in the elderly and bilitated, and response to Gantanol (sulfamethoxazole) ɔften highly satisfactory. The usual precautions in lfonamide therapy should be observed, including aintenance of adequate fluid intake, frequent c.b.c.'s d urinalyses with microscopic examination.

Make the therapy suit the infection

In most urinary tract infections the *b.i.d.* schedule will usually suffice, but therapy must be maintained long enough to ensure eradication of pathogens. Mounting evidence in current medical literature suggests a minimum of 14 days of continuous therapy.* Adequate treatment for a sufficient time may also help prevent possible kidney damage. Gantanol is generally well tolerated with relative freedom from complications. The most common side effects include nausea, vomiting and diarrhea. Prescribe Gantanol tablets or the pleasant-tasting suspension.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

In nonobstructed cystitis due to susceptible organisms

Gantanol® B.I.D. (sulfamethoxazole) Basic Therapy

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N.J. 07110

Please see following page for summary of product information.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. ***Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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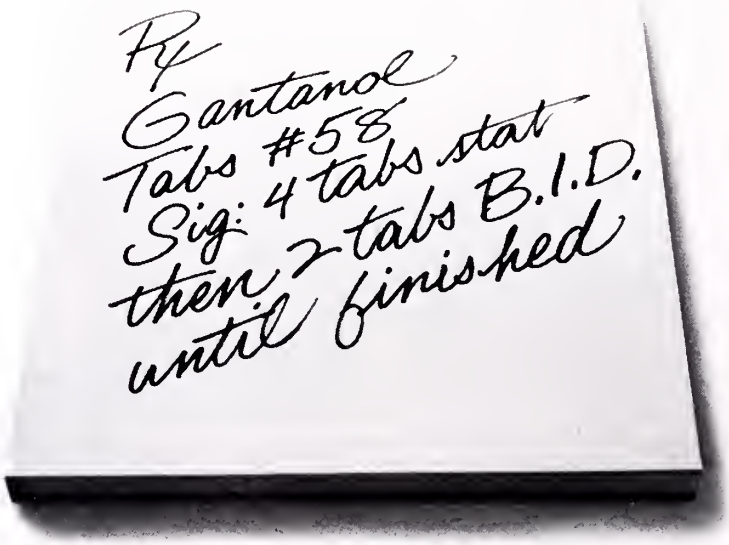
Nutley, N.J. 07110



In nonobstructed cystitis due to susceptible organisms

Gantanol® (sulfamethoxazole) B.I.D.

Basic Therapy

Classified Ads

physicians wanted

Family Practitioners

WANTED—Family practitioner to join established physician in busy two-doctor practice. Salary and/or percentage first year with PA benefits. Lower Florida East Coast. Phone (305) 732-2701.

FAMILY PRACTITIONER to join 15 man multi-specialty group in Central Florida. Excellent fringe benefits together with pleasant working facilities in an area famous for excellent recreational opportunities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

FAMILY PRACTITIONER to join twenty-three multispecialty group in St. Petersburg within next twenty-four months. Excellent financial arrangements, corporate benefits, and recreational facilities. Please send curriculum vitae, C-596, P.O. Box 2411, Jacksonville, Florida 32203.

CENTRAL FLORIDA AREA: Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

FAMILY PRACTITIONERS WANTED: One of the fastest growing communities in the U.S., Seminole, Florida, urgently needs family practitioners. Only minutes from Tampa, St. Petersburg, Clearwater and beach areas. Newly opened 100-bed acute general hospital. Offices provided on hospital property with rent free provisions. Will assist in referrals of patients. Write or phone Carlton K. Flores, Administrator, Lake-Seminole Hospital, 9675 Seminole Boulevard, Seminole, Florida, 33542. Phone (813) 393-4646.

GENERAL PRACTICE: Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

INTERNIST, board certified or eligible, to join 3-man internal medicine department in growing 15 man multispecialty group located in Central Florida. Subspecialty in cardiology, hematology, or rheumatology desired but not necessary. Excellent fringe benefits. Area combines best of rural living with easy access to metropolitan cultural activities. Contact Tim N. Howell, M.D., Gessler Clinic, P.A., 635 First Street North, Winter Haven, Florida 33880. (813) 294-3232.

WANTED: ALLERGIST OR EAR, NOSE, AND THROAT ALLERGIST, part or full time to associate with established ear, nose, and throat group in the Palm Beaches, Florida. Salary open plus corporate fringe benefits. Contact Robert G. Wilms, Office Manager, Palm Beach Ear, Nose and Throat Association, 1515 North Flagler Drive, West Palm Beach, Florida 33401.

PHYSICIANS WANTED: General practitioner, internist or physician with surgical training, to join six man medical group in metropolitan Miami area. Excellent unlimited earnings opportunity. Percentage with guaranteed minimum. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 East 25th Street, Hialeah, Florida 33013. Phone (305) 696-0842.

UROLOGIST WANTED: Association leading to partnership in expanding Florida community, equally distant from both coasts. Florida license and board certification required. Write C-614, P. O. Box 2411, Jacksonville, Florida 32203.

UROLOGIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-621, P. O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-622, P. O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIC SURGEON: Attractive opportunity in North Central Florida. Community has well-equipped, new 128-bed hospital and does not currently have an orthopedic physician. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

INTERNIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-619, P. O. Box 2411, Jacksonville, Florida 32203.

OTOLARYNGOLOGIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-620, P. O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Board qualified or certified to join four established internists—general internal medicine. Salary first year, percentage and partnership to follow. Write Pompano Medical Group, P.A., 2480 N.E. 23rd Street, Pompano Beach, Florida 33062. Phone (205) 942-0100.

Miscellaneous

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. Hematologist, Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccousukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

ER PHYSICIANS: Florida licensed ER physicians needed to join well established group providing ER coverage for 400-bed general hospital located on Florida west coast. Excellent fringe benefits including one month vacation per year and paid Blue Cross/Blue Shield benefits. Ideal working conditions in an area famous for its climate and recreational opportunities. Please send curriculum vitae, C-624, P. O. Box 2411, Jacksonville, Florida 32203.

TWO PHYSICIANS FOR THE HEALTH DEPARTMENT CLINIC in Immokalee, Florida. Will work for the Florida State Division of Health. Physicians with FMG certificates eligible. Spanish helpful. Call Gunnard J. Antell, M.D., Director, Collier County Health Department. Phone: (813) 774-8962.

WANTED CENTRAL FLORIDA: GP, INTERNIST AND PEDIATRICIAN to join four man group well established in a community located in the heart of citrus and cattle country. New 50-bed hospital directly across from office. Excellent educational and recreation facilities. Please send curriculum vitae to Barbara C. Carlton, M.D., P.O. Box 1270, Wauchula, Florida 33873.

TIRED OF A FULL SCHEDULE WITH NO TIME to relax and enjoy yourself? Like to make a good salary, with little or no overhead and have time to enjoy yourself in warm, sunny Florida? The Brevard Mental Health Center needs a physician to work in its alcohol and drug abuse programs. Limited private practice allowed. Full fringe benefits including hospitalization, retirement and liability insurance. Contact Dr. George Rodon, Acting Medical Director, 1770 Cedar Street, Rockledge, Florida 32955.

INTERNIST, FAMILY PRACTITIONERS: Central Florida area, Orange County. Area combines best of rural living with easy access to metropolitan area 11 miles away. Privileges available in expanding hospital. Contact Robert Barber, Administrator, West Orange Memorial Hospital, 555 North Dillard Street, Winter Garden, Florida 32787. Phone (305) 656-1244.

ALL TYPES OF PHYSICIANS NEEDED in fast growing Ocala. Brand new 126-bed Hospital of America just opened. $5,000 expansion program underway at Munroe Memorial Hospital. Immediate occupancy available in centrally located physicians complex, with unlimited parking, all utilities, and janitor services. Several suites available. Will renovate to suit tenant. Contact E. E. Conrad, Box 216, Silver Springs 32688. Phone (904) 236-2343.

OTOLARYNGOLOGIST, ANESTHESIOLOGIST, E. R. PHYSICIAN AND GENERAL PRACTITIONER. Guarantee, loan and free rent in new professional building available. Contact Claude Weeks, Administrator, Flagler Hospital, P. O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

WINEMAKING—A quiet retreat from the hectic cares and responsibilities of the day. Send for free informative catalog. Arbolyn Wines, 829 Knox Abbott, Cayce, S. C. 29033.

DEVELOPING MULTISPECIALTY GROUP oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Internists, Cardiologists, Pediatricians, General Surgeons and General Practitioners. Contact: H. D. Williams, M.D., President, Williams, Abbey & Sells, M.D.'s, P.A., Richey Medical Center, P.O. Box 1000, New Port Richey, Florida 33552. (813) 842-8494.

EMERGENCY ROOM PHYSICIAN—FLORIDA CAPITAL CITY: to join other physicians in full E.R. coverage of 511-bed general hospital. 42 hour week, Florida license required. Beautiful location in university town, abundant fishing, water sports and hunting. Excellent schools, choice home sites. Minimum income of $40,000 with opportunity to increase. Contact Dr. George H. Evans, Chairman, Emergency Room Committee, Tallahassee Memorial Hospital.

PART OR FULL TIME PHYSICIAN for Student Health Center at the University of South Florida. If interested, please contact Larry E. Stevens, M.D. (813) 974-2331, University of South Florida, 4202 Fowler Avenue, Tampa, Florida 33620. An Affirmative Action Equal Opportunity Employer.

situations wanted

UROLOGIST: Completing University training July '74. Age 30, married, board eligible, Florida license. National boards, desires association leading to partnership or group practice anywhere in Florida. Fred P. Sherman, M.D., 20 Lakeview Avenue, Apt. C, Leonia, N.J. 07605. Phone (201) 461-2538.

INTERNIST: Board certified. Full cardiology training. Young family. Practice or hospital association desired in southern Florida. Available July 1974. Sooner possible. Robert Stults, M.D., 871 Rorke Way, Palo Alto, Calif. 94303.

CANADIAN CARDIOLOGIST, early forties, Florida license, wishes to join group or individual in private practice, American trained. Write C-625, P.O. Box 2411, Jacksonville, Florida 32203.

UROLOGIST, 30, married. Board eligible, university trained. Seeking association, partnership or group affiliation. Available June 30, 1974. Harris D. Slavick, M.D., 15 Merion Lane, Willingboro, New Jersey 08046. (609) 871-9619.

INTERNIST: Board certified, Florida license, in military service, available part time for internal medicine consultations, ECG interpretation. Central Florida area, will travel. Write C-618, P.O. Box 2411, Jacksonville, Florida 32203.

ALLERGIST—Chest physician, age 43, certified allergy. Academic position university-affiliated hospital; head, chest and allergy sections. Experienced chest disease, pulmonary function lab, tuberculosis, RICU, etc. Desires association with established practice, group or consider progressive hospital lab. Inquiries: John McCloskey, M.D., 2380 Packard Ave., Huntingdon Valley, Pa. 19006.

UROLOGIST, Board qualified, age 31, military completed June 74. Desires association with established urologist leading to partnership. Write: Stuart Wanuck, M.D., 28 Riverside Ave., Red Bank, N. J. 07701 or call (201) 747-1818.

practices available

ESTABLISHED-SUCCESSFUL FAMILY PRACTICE. No OB. Architecturally well appointed 1800 sq. ft. office. Four examining rooms cypress paneled and sound proofed. Private office for M.D., one block from 530-bed hospital. Located in cultural center on beautiful West Coast of Florida. Address all inquiries to: 3624 Duncan Place, Sarasota, Florida 33580.

real estate

PRIVATE SUITES FOR IMMEDIATE OCCUPANCY: New 18,000 sq. ft. building with excellent parking. South Miami Medical Arts Building. Walking distance to Larkin and South Miami hospitals. Call 665-7523 or 667-3694.

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

ORLANDO—MEDICAL SUITE in modern building, prime location, near hospitals and schools, loads of parking, doctors needed in this area. Phone: (305) 293-6020.

PRESTIGE OFFICE AVAILABLE for immediate occupancy. 1,040 square feet located directly opposite major hospital, ideal for specialty practice. Contact Dr. Leo Conn, 921 N. 35th Avenue, Hollywood, Florida 33021. Phone (305) 966-2268.

VENICE: NEW ULTRAMODERN THREE STORY DOCTORS GARDENS BUILDING now under construction directly opposite the Venice hospital. Occupancy January 1974. Design your office requirements while under construction. Contact: Dr. Sheldon Wald, 2700 S. Tamiami Trail, Sarasota, Florida 33579. Phone (813) 955-4323.

FOR RENT: Facing Memorial Hospital, Hollywood, Florida. From 1,000 to 4,000 square feet. Contact Yale Citrin, M.D., 3435 Johnson Street, Hollywood, Florida 33021. Phone (305) 989-7441.

DENTIST OR DOCTOR'S OFFICE: 750 square feet. Ideal location San Marco area. Available March 1, 1974. Contact: M. V. Corporation, 3412 Sunnyside Drive, Jacksonville, Florida 32207. Phone (904) 398-7561.

VENICE, FLORIDA: IMMEDIATE OCCUPANCY: A few suites custom designed to your specifications, are available in this recently completed professional building. Maintenance, heating, and air conditioning are provided. Contact the Management, Suite 150, the 400 Building, 400 South Tamiami Trail, Venice, Florida 33595, Phone 485-2015.

equipment for sale

FOR SALE: 280 KV Picker Vanguard Therapy unit. Excellent condition inexpensive supplement to already established radiation therapy department. Contact Joseph L. Ackerman, M.D., 1717 North Flagler Drive, West Palm Beach, Florida 33407. Phone: (305) 832-1703.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 1000. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Nutley, N J. 07110

to help reduce clinically significant anxiety and thereby help improve patient receptivity

Librium® up to 100 mg daily in severe anxiety (chlordiazepoxide HCl)

Please see following page.

Symptom of excessive anxiety:

The patient may have difficulty in accepting medical counsel.

Clinical experience has shown that some unduly anxious patients may tend to deny or minimize their illness and therefore resist seeking or following medical advice. Through its antianxiety action, adjunctive Librium (chlordiazepoxide HCl) can often calm the emotionally tense patient, thereby encouraging physician-patient rapport and, on occasion, making it easier for the patient to accept medical counsel.

for relief of excessive anxiety

ROCHE

(c

Please see reverse side for summary of product information.

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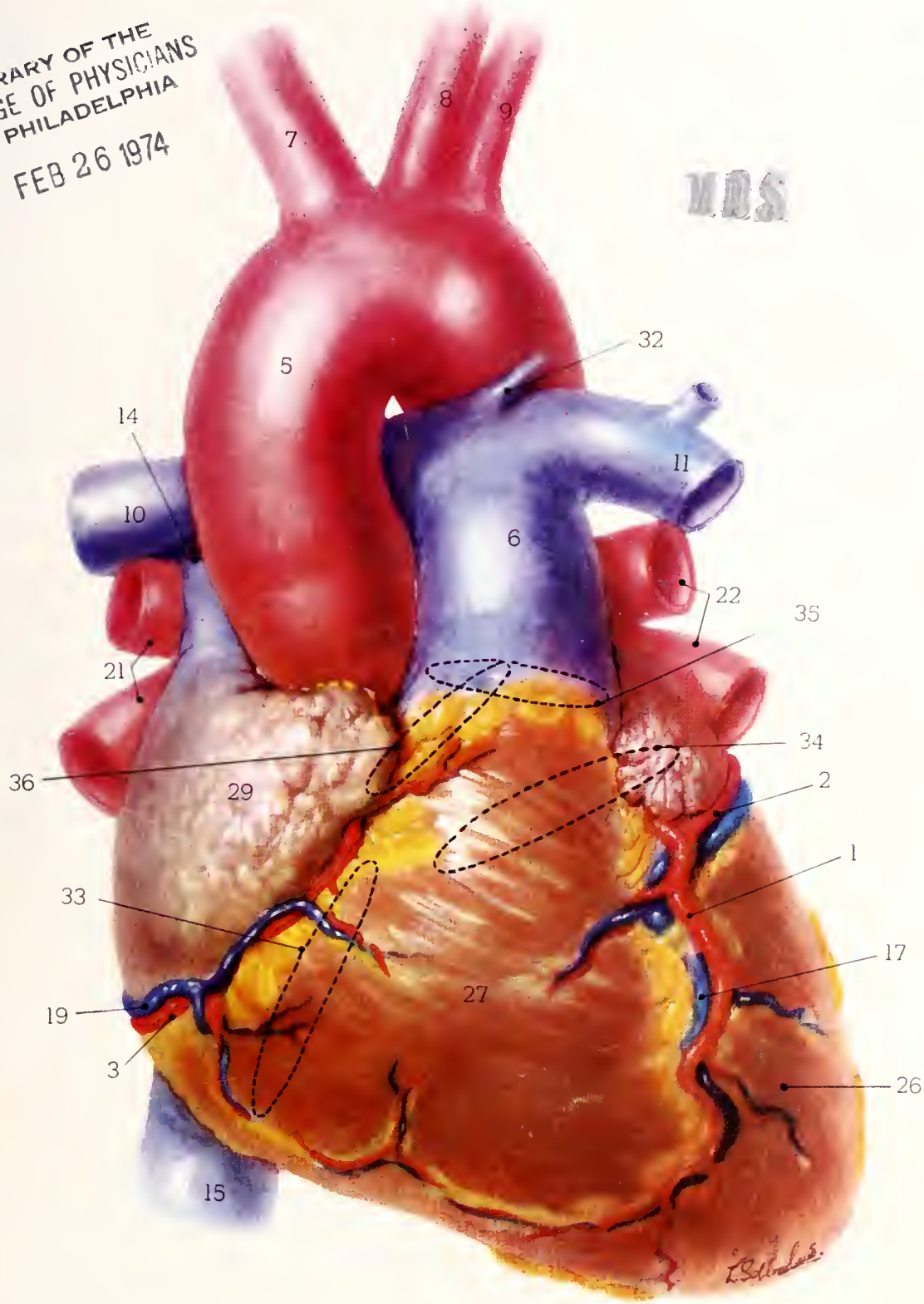
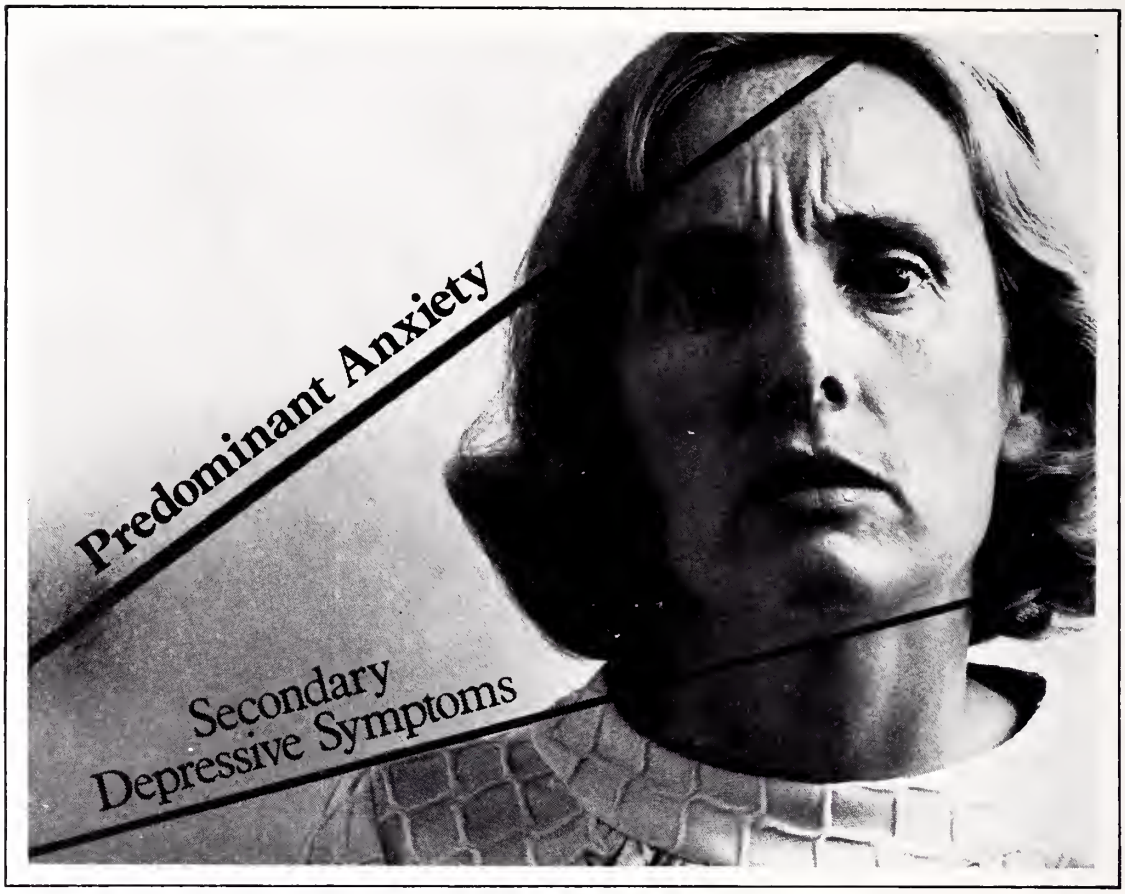


FMA Centennial Meeting — Diplomat Hotel — Hollywood — May 8-12, 1974



This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex to Valium® (diazepam)

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Valium® 2-mg, 5-mg, 10-mg tablets
(diazepam)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

FEBRUARY, 1974 VOLUME 61 • NUMBER 2

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FEBRUARY COVER—Weighing well under a pound and only a little larger than one's fist, the human heart is a hardworking organ which, until recently, was the most essential item of equipment necessary for one's longevity. Nowadays, however, as an essential segment of the cardiovascular surgeon's domain, its rhythm is regulated, it is stopped and patched, its circulation is restored and, subject to the philosophy of modern American economy, as a wornout piece of machinery, it is even replaced.

With the help of the Florida Heart Association, whose symbol appears to the left, the cover was designed as a refresher in anatomy, as a reminder that cardiac disease is inversely proportioned to good health habits, and as support for this worthwhile organization in its annual fund drive this month. See page 181 for legends.

President's Page

PSRO

The purpose of this editorial is two-fold: To inform you NO special meeting of the House will be called to consider the FMA position on PSRO;* and to solicit your opinion on the most effective approach in dealing with the PSRO problem.

In 1973, the FMA Board of Governors considered the PSRO legislation to be unnecessary, undesirable, ill-conceived, poorly formulated, and destined for failure; however, faced with the alternative of having this program regulated by groups of political appointees *or* by Florida doctors operating in the coordinated framework of our statewide organization, the Board recommended the latter. The House of Delegates in May, 1973, approved the formation of a statewide PSRO corporation. By these actions, the FMA has acted in good faith. HEW, on the other hand, has responded negatively and has refused to approve the PSRO Corporation formed by the FMA. It favors, instead, the fractionated administration by several smaller groups. The multiple contracts and varied directives emasculate the very unity of the FMA's 9,200 members. In addition, in my opinion, regulations are arbitrary, inflexible and totally unacceptable. It is apparent that HEW failure either to approve the PSRO corporation or to formulate regulations which permit adequate medical care will force us to reconsider our position on the PSRO concept.

Since the potential effects of any new approach could be far-reaching, it is important that this whole matter be discussed and aired thoroughly by Florida physicians. If we were to react hastily without regard for the considered and educated opinions of our membership, we would be subject to the same criticism which we levy upon Congress for the manner in which it enacted the PSRO legislation. We hope that at the 1974 annual meeting of the House of Delegates, actions will reflect the consensus and receive the support of a vast majority of our members.

FMA officers and directors will continue to watch developments closely with due consideration for the opinions, advice, and suggestions which we expect to receive from you. We appreciate the help and support which you have provided so consistently.

---

* *The House of Delegates policy regarding PSRO as adopted in 1973 is as follows: 30. PSRO (Professional Standards Review Organization)—After long and arduous deliberation, your Board of Governors reluctantly authorized the establishment at the earliest possible date of the Florida Professional Standards Review Organization, Inc. This organization will file an application with the Department of Health, Education and Welfare to be designated as the professional standards review organization for the State of Florida based on Public Law 92-603 (HR-1). The primary purpose of this corporation is to serve as the prime contractor for the State of Florida, providing all statistical, computer and support services to and for not less than 12 local PSRO's who shall provide all local review and professional services. (R.C.V)*

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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See **DOSAGE AND ADMINISTRATION**)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

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No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

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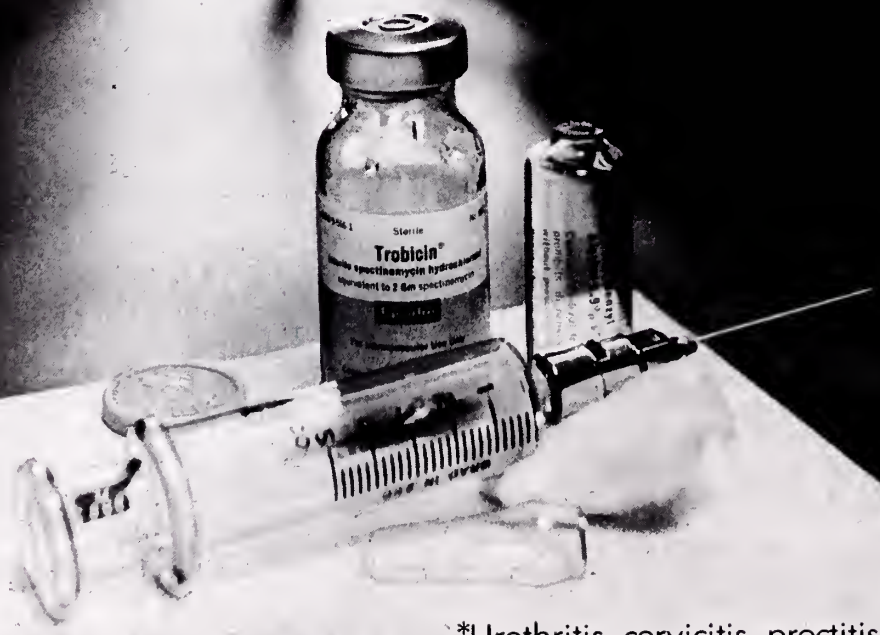

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphotase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

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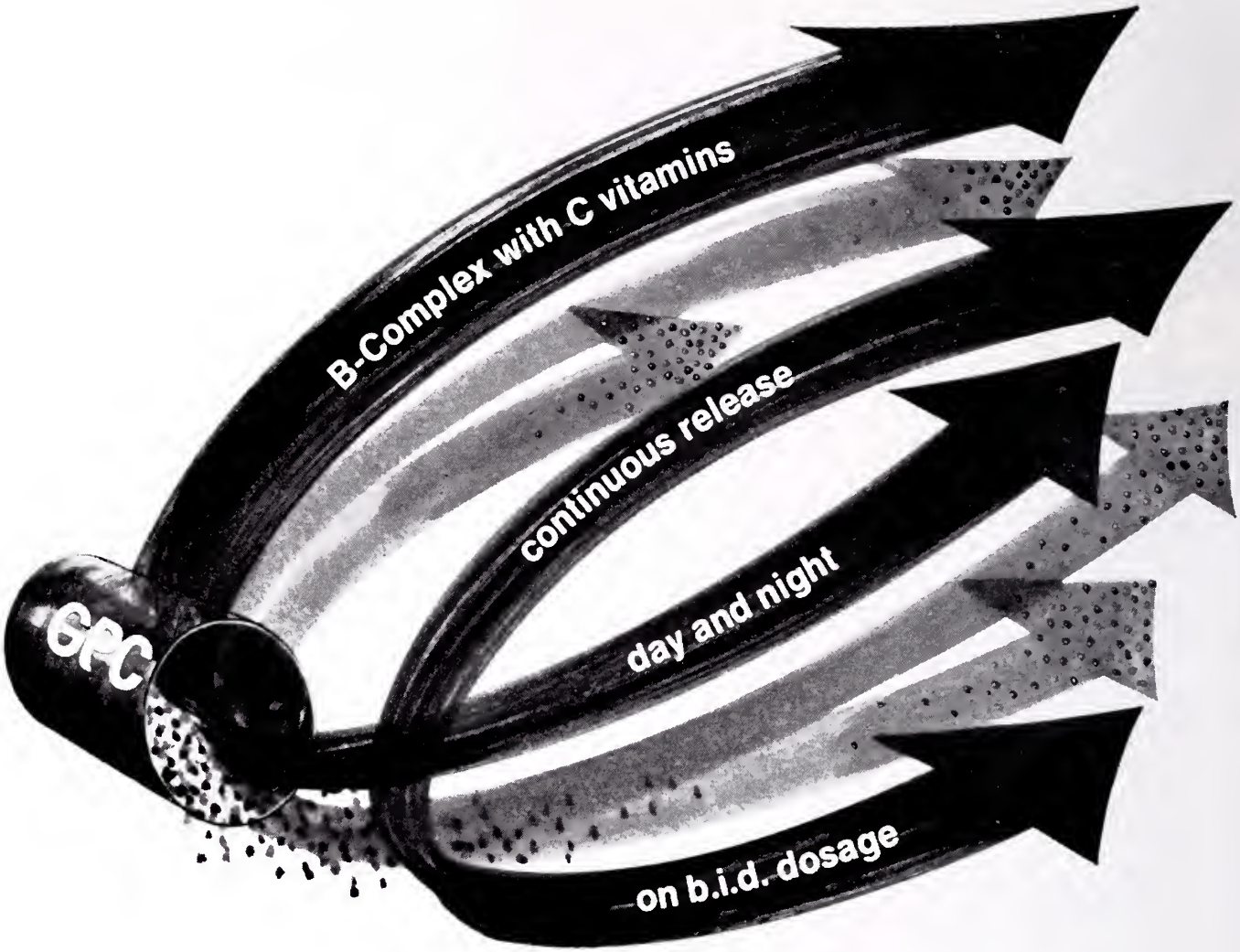
The Upjohn Company, Kalamazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.



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Niacinamide	50 mg
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Belladonna alkaloids for antispasmodic benefits.

Powdered opium, the therapeutic equivalent of paregoric—without the unpleasant taste—to promote the production of formed stools and lessen the urge.

And a delicious banana flavor good enough for the most discriminating tastes.

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Donnagel with paregoric equivalent.
Each 30cc. contains:

Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP	24.0 mg.
(equivalent to paregoric 6 ml.)	
(warning: may be habit forming)	
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

℞ Available on oral prescription or without prescription in compliance with applicable state and local law

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Glyceryl guaiacolate ..... 100 mg.
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Each 5 cc. contains:
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Codeine phosphate ..... 10.0 mg.
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Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control

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Glyceryl guaiacolate ..... 100 mg.
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Alcohol, 1.4%

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COUGH CALMERS®	■	■	■		■

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Dean's Page

Continuing——?

Donn L. Smith, M.D.

If the title for this brief discourse is not entirely clear, it is appropriate for the subject which is equally in need of clarification. The subject is, of course, continuing education for physicians. The merit and necessity related to lifelong scholarship in medicine has been extolled by a great number of generations of medical educators and distinguished physicians. Many of our predecessors, both educators and physicians. have indeed engaged in effective continuing education, mostly on a self-generated, self-education basis. Those who have done so learned something that succeeding generations of physicians in Florida are also going to learn. That is, truly operative continuing education entails a great deal of hard intellectual effort, requires adequate time, and is best accomplished by a set period of time, reserved almost daily for the purpose.

For the past 15 years, extensive and expensive programming has been conducted, particularly by medical schools and specialty organizations, all designed to bring new knowledge and the physician together. The new rules adopted by several state societies regarding a required number of hours of continuing education for physicians provide eloquent testimony relative to the success of these past years of activity.

There is, what seems to me to be, an unfortunate tendency to assume that the fault lies primarily with the practicing physician. I would submit what is probably a minority opinion, that the basic problem lies within the province of those who have been given, or have assumed, the responsibility for the usual program in continuing education. I believe strongly that the majority of practitioners do want to remain abreast of modern medicine and do worry about their practice in terms of giving the patient the best care available. One of the major problems has been that continuing education has been largely equated with travel to some attractive area, an opportunity to spend some time with one's family with perhaps some additional travel to follow. While this is all very understandable and not necessarily bad, the question is, why, with all of the great number of such courses available, it has not worked, and why is it necessary to prescribe a certain number of hours of obligatory attendance?

There are a large number of variables which contribute to what appears to be a significant problem of dissatisfaction with our current program in continuing education perhaps at the national level and certainly at the state level in a number of states; however, there is one factor which may prove to be of importance and which should be considered; that is, a clear and obvious lack of participation by the attendee in many cases. Out of town, nationally recognized individuals are recruited to make presentations, panels are formed to provide discussion and the audience sits and listens or takes a local tour, but in the main adopts and functions in an almost entirely passive role. While all things are relative and there is no way to document the significance of participation or lack thereof in this setting, it is certainly not very difficult to suggest viable alternatives.

One idea that has been tried and found to be good is a biannual symposium by the hospital staff, in which members of the staff make presentations, construct discussion panels and add outside talent as deemed necessary. Most of the

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

participants and presentors know each other, and questions and comments flow more freely. No travel is involved, emergencies may be handled and everyone comes to realize that there is a substantial amount of competency immediately available on one's own hospital staff. Those requested to participate from the medical school or elsewhere are few in number and are honored guests rather than an isolated group of paid performers. The active participation of the practicing physicians in the construction of the program, its scheduling and content provide a vested interest that has productive impact on the entire group in terms of what may be learned. A poor or unsatisfactory program has local effect and will require measures to be taken leading to possible improvement. Those staff members who feel that they or their section can do better are likely to gain an opportunity to do so. These benefits, I believe, are meaningful and helpful in the overall consideration of how to communicate information and knowledge.

There are no doubt many other new and innovative ways in which the current level of continuing education may be upgraded. Whatever methods evolve, a viable feeling of participation and responsibility must be made possible for every physician involved. There is not a chance that this important task can be successfully achieved without effort and concern on the part of every physician. There is no truly easy way to learn, and continuous, intelligent effort and work will be a necessary prelude to any visible improvement in the situation.

Medical schools and specialty groups can and should be of major help, but it is not going to be possible for them to accomplish the complete task. Significant assistance must be rendered by those whose situation requires that they improve their individual level of medical education for the purpose of achieving a superior level of medical practice.

▶ Dr. Smith, University of South Florida, Tampa 33620.

FMA Centennial Annual Meeting, 1974

The 1974 (Centennial) Annual Meeting of the FMA will be held at the Diplomat Hotel in Hollywood, Florida, May 8-12. Friday, May 10, has been set aside for a special celebration commemorating the 100 years that FMA has served the physicians and the citizens of Florida. A very special program is in the making on Friday—one that will:

Bring a Smile
Make Your Spine Tingle
Warm the Heart
Moisten the Eyes
Strengthen the Conscience
and
Pay Tribute to an Honorable Profession and
many of its Honorable Men.

You will be hearing more about the activities to be scheduled throughout the year, but plan now to attend the 1974 Annual Meeting and participate in the Centennial Celebration—after all *You Are The FMA* and it's *Your Birthday.*

Must vasodilators and therapy for other diseases come into conflict?

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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- **Antibiotics to combat susceptible bacteria and fungi**
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BRIEF SUMMARY: Indications: All indications are predicated upon infections due to organisms susceptible to neomycin or tyrothricin, or to the undecylenate salt of neomycin. Otitis Externa (acute and chronic)—Fungal infections (such as *Monilia* and *Aspergillus*). **Contraindications:** Tuberculous and most viral lesions (herpes simplex, vaccinia, and varicella particularly); less common fungal infections (other than *Monilia* and *Aspergillus*); hypersensitivity to any of components. **Precautions:** Use with care in cases of perforated eardrum or long-standing otitis media because of possibility of ototoxicity. As with all antibiotics, prolonged use may result in overgrowth of non-susceptible organisms. If superinfection occurs, appropriate measures should be instituted. There are reports in medical literature indicating increased incidence of persons sensitive to neomycin. **Side effects:** Apparent allergic reactions with such symptoms as crusting, swelling, vesicular rash of the external canal or increase in discharge reported in 1.2% of patients treated; transient warmth or burning sensation on instillation, in 2.7%. **Dosage:** 2 to 5 drops, b.i.d. to q.i.d., or the wick method, with the wick moistened b.i.d. to q.i.d., until disease has cleared or become static. **NOTE:** Refrigerate until dispensed. After opening, keep at room temperature; unused contents should be discarded after 14 days. *BIBLIOGRAPHY AVAILABLE ON REQUEST.

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Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

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A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

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ANTIMINTH®

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equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

FEEDBACK - from Pearl Street

Antibiotic Sensitivity Patterns

Dr. William B. Deal of the William A. Shands Teaching Hospital and Clinics, J. Hillis Miller Health Center, Gainesville, and Dr. Alexander G. Vandevelde of the University Hospital of Jacksonville provided this summary report of antibiotic sensitivity patterns (percent of strains) in their institutions for six months January-June 1973 and 12 months 1972 respectively.

Organism	Number Strains		Antibiotic Ampicillin		Carbenicillin		Cephalothin		Chloramphenicol		Clindamycin		Colistin		Erythromycin		Gentamicin		Kanamycin	
Institution	U	S	U	S	U	S	U	S	U	S	U	S	U	S	U	S	U	S	U	S
Acinetobacter anitratus		44		23		83		2		37				97				97		84
Bacteroides funduliformis		175		18				19		99		94				80				
Bacteroides species		129		86				79		100		100				98				
Citrobacter species	39	53	18	26	43	56	16	45	97	84				96			100	100	92	82
Clostridium species		126		100				98		100						93				
Enterobacter aerogenes		183		6		71		17		92				97				100		99
Enterobacter cloacae		364		7		72		3		94				97				99		95
Enterobacter species	223		4		38		12		99								100		96	
Enterococci		959		98		15		7		92								1		
E. coli	1031	2385	59	75	73	72	84	91	97	97				99			100	99	93	93
Klebsiella aerogenes		1104		5		4		97		91				99				99		96
Klebsiella species	606	27	1	13	3		89	86	99	86				95			100	90	89	80
Mima herellea	42		22		30		19		66								98		88	
Proteus mirabilis	308	1456	87	90	87	95	95	90	92	97				1			99	99	97	98
Proteus species	85	55	18	16	71	89	31	14	81	87				6			100	100	100	93
Providence		16		18		73		7		86				12				81		78
Pseudomonas species	882	1203	1	1	16	74	1	1	3	10				98			99	85	5	5
Serratia	30	91		6	31	72	7	3	100	90				9			100	98	93	92
Staph. Coag. pos.		925						99		99						96		99		
Staph. epidermidis	533		65				97		94			77			70		98		88	
Staph. aureus	213		25				100		98			91			94		100		82	
Staph. Coag. neg.		1530						97		94						82		99		
Strept., Group D	190		99				71		91			11			80		49		18	
Strept., Other	178		92				99		98			94			97					

U = University Hospital

S = Shands Teaching Hospital

Organism	Methicillin		Nalidinic Acid		Neomycin		Nitrofurantoin		Oxacillin		Penicillin		Polymyxin		Streptomycin		Sulfonomides		Tetracycline	
INSTITUTION	U	S	U	S	U	S	U	S	U	S	U	S	U	S	U	S	U	S	U	S
Acinetobacter anitratus						100		4								79				97
Bacteroides funduliformis												8								70
Bacteroides species												69				60				87
Citrobacter species			86			100	86	92					94			66	71		77	71
Clostridium species		99										100								95
Enterobacter aerogenes						100		93								93				91
Enterobacter cloacae						100		90								89				89
Enterobacter species			98				82						91				90		96	
Enterococci						64		97												16
E. coli				99		100	98	98					94		67	76	73		83	75
Klebsiella aerogenes						100		90								86				85
Klebsiella species		9	96				83	72					91		67	63	74		93	77
Mima herellea			100										100				100		76	
Proteus mirabilis			98			66	5	3					2			94	89		1	5
Proteus species			97				12	20								70	65		24	41
Providence								25								75				46
Pseudomonas species			1			53		1					94			3	88		6	4
Serratia			75					8					22			61	50		57	17
Staph. Coag. pos.		99				100						20				96				89
Staph. epidermidis									90	35					79		53		56	
Staph. aureus									97	13					79		55		93	
Staph. Coag. neg.		91				89						31				82				49
Strept., Group D							100		9	74					2		1		32	
Strept., Other									91	99					8		27		67	

U = University Hospital

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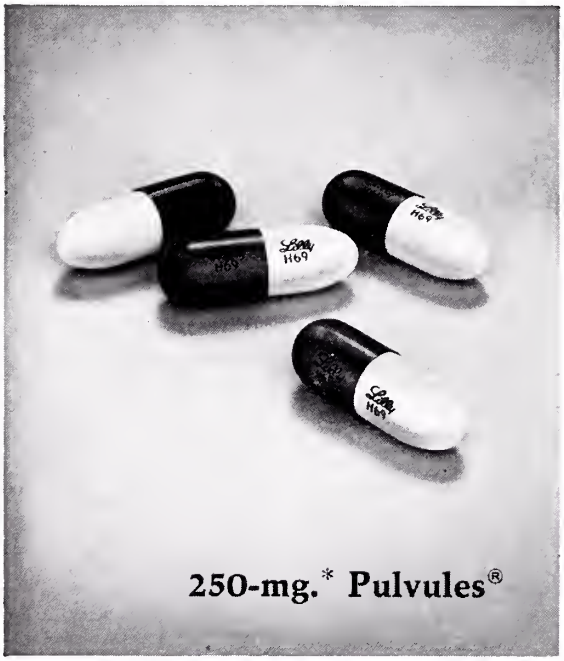

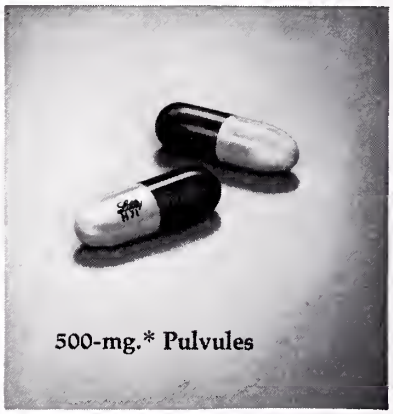

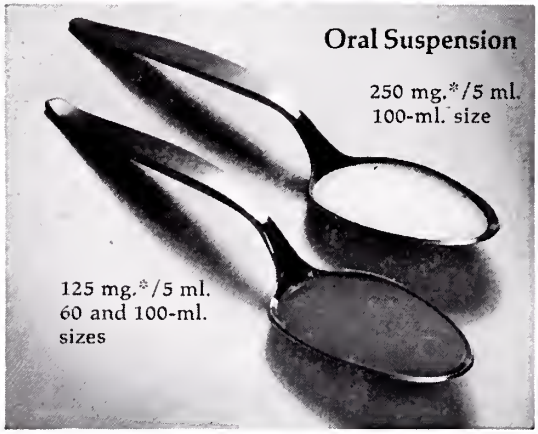

*Equivalent to cephalexin.

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PSRO, Quality Assurance, Audit and Education

A Solution

EDWARD W. ST. MARY, M.D.

Abstract: An algorithm is suggested in a module fashion for the improvement of patient care and continuing medical education. This would incorporate the problem oriented record, acquisition of comparative data, establishment of criteria of care, self and/or in-hospital audit. The end result would be a stimulus for meaningful continuing medical education with better quality patient care. With true medical leadership, the unpleasant effects of PSRO and QAP would be mitigated while still providing a better medical system. The plan suggests a cooperative merger of independent plans of this system into a pluralistic master plan with the hospital and private physician providing the necessary guidance.

Continuing Medical Education (CME), Medical Audit, and Quality Care have become more prominent on the medical scene. Little has been said collectively about these and other combinations used in parallel and interdependently for better health care delivery. These combinations specifically are the Problem Oriented Medical Record System (POMR), Professional Activity Study-Medical Audit Plan (PAS-MAP), Quality Assurance Plan (QAP) and Professional Standards Review Organization (PSRO) (Fig. 1).

Nothing is really new except PSRO. Although the regulations have not yet been written, there is little doubt that this too can be implemented into a master plan, easily adaptable as a module to be added to the overall scheme or pattern of patient care.

Board of Trustees Role
The Darling Decision

The Darling Decision[1] held that the hospital and the Board of Trustees are responsible for providing quality care for all of the patients at all times. The hospital then has the right and responsibility to evaluate that care in all its aspects. This includes a very responsible role and influence in quality care, audit and continuing medical education of all those having involvement in patient care.

Quality Assurance Program

One of the greatest benefits of the QAP as advocated by the American Hospital Association is the inclusion of physicians in the medical management of the hospital. The Program is a Peer Review mechanism within the hospital combining the activities of the Utilization, Medical Audit, Records, and, in many cases, the Professional Standards Committee.

PAS-MAP

Since 1955 the Professional Activity Study-Medical Audit Plan (PAS-MAP) established by Slee[2,3] has been a means of reviewing data from different areas, countrywide or worldwide. This data material pertaining to disease is available to the physician, research groups, and hospitals sub-

scribing to the plan. From such data feedback, criteria can be set up by individual hospitals for quality care and education. This PAS-MAP system is present in over 1300 hospitals in the United States. It covers 20 million discharges to date. Slee has repeatedly stated that most of the care most of the time is not adequate—that good care is not accidental but rather the systematic approach to the problem.

Criteria

This next module or function is to first establish criteria from the data received. Whether such data come from the PAS-MAP program or any other comparative study is immaterial. What is important is the setting up of criteria of care of illnesses at that hospital's level of knowledge and competence. The criteria of Payne,[4] the AMA Guide,[5] or others do not mean that these should be the individual hospital's criteria. These should be set up by the individual medical and surgical services of the hospital. The staff should vote on such changes and add or subtract criteria as the level of competence decreases or increases.

The physician is the only effective evaluator of care. Evaluation is a question of what data need to be defined and what data need to be added to the criteria list. The practice of medicine really is determined by the way you think and handle the data after they have been accumulated. The quality of your care is determined by the way you discipline yourself to handle the data you have received.

To make this committee effective and accurate demands a knowledge of the data and an even greater knowledge of criteria for care. The data

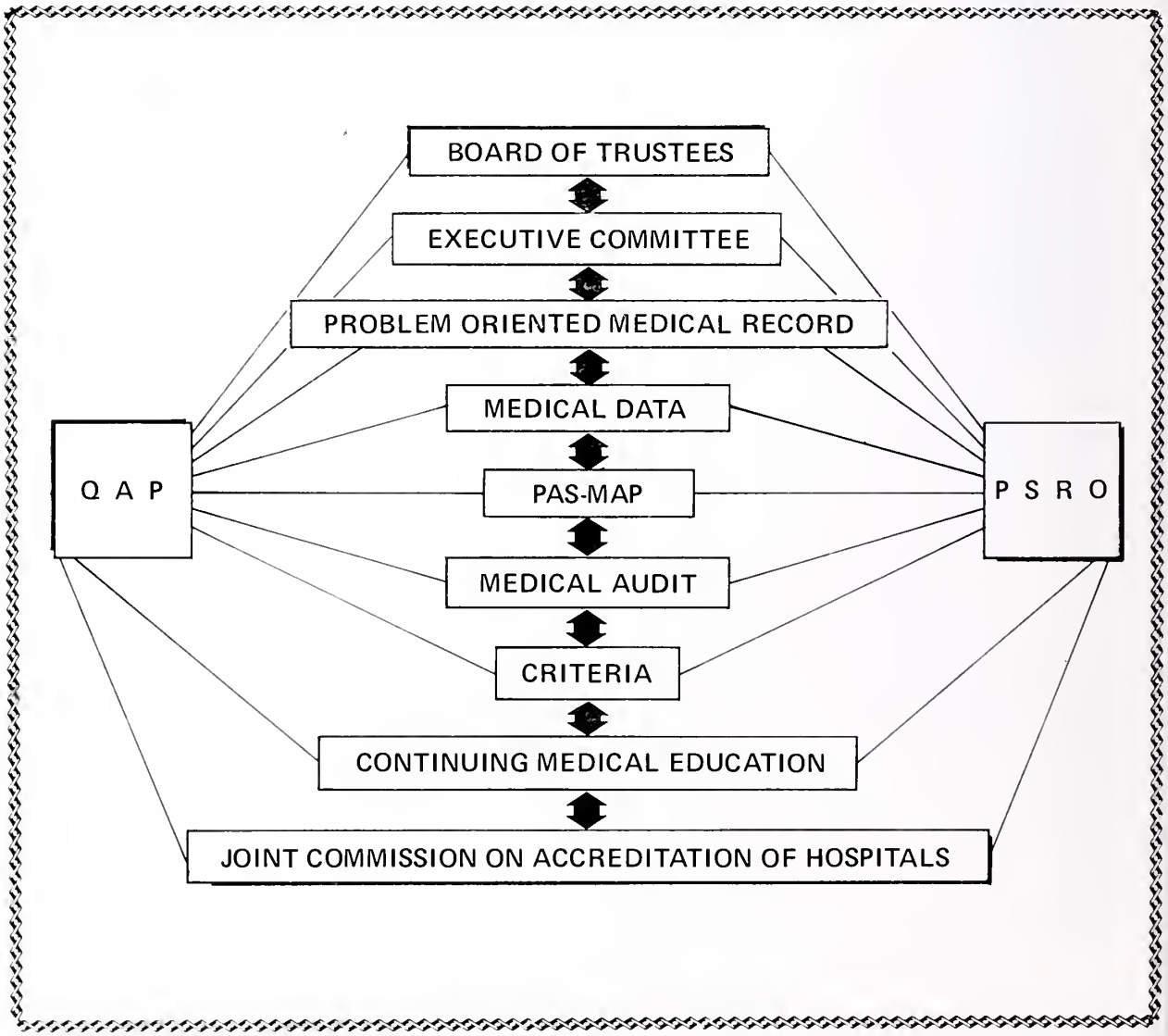

Figure I

and criteria must be used. Knowing the criteria should be a function of the individual departments of the hospital. Much help in this can be offered by reviewing articles by Payne,[4] the Peer Review Manual of the American Medical Association,[5] Lembcke,[6] and others.

Internal Medical Audit

From the established criteria the next constructive module is the internal audit. Internal audit means that audit done within the hospital. It should be of such quality to equal or surpass the requirements of the Joint Commission on Accreditation of Hospitals, (JCAH), QAP, PSRO, or any other audit plan submitted to us. Most of all, an audit should be generated by the physicians themselves who are cognizant of the quality rules and responsibilities as delegated by the Board of Trustees.

Audit appears to be our weak link. Comparative studies (PAS-MAP or others) will aid in crystalizing our opinions and overcoming our temerity in dealing with our colleagues. The fact remains that if you cannot audit a record for quality, you do not have the knowledge of quality or the ability to produce that quality. If the criteria have not been explicit, then it is impossible to evaluate what you are doing; you will not know what you are doing since you have not established the criteria.

This then will have to be one of our biggest changes outside of adapting to a newer, more efficient way of medical record keeping to help promote better health care delivery and evaluation.

By not having a high quality internal audit we are exposing ourselves more vulnerably to external, third party or other nonprofessional interference. By gradually adapting to a modular approach, we will find, by altering a discipline here and there, keeping our established and exploring new features, we will be in a position of already performing a large number of future requirements these same regulations will spell out. If they are not by law, the system is still better than the disorganized system now present.

Medical Records

Proper medical records are a must in the system. The Problem Oriented Medical Record originated by Weed[7,8] in the mid-1950's and promulgated and expanded upon by Yarnall,[9] Hurst,[10] and others[11] lends itself ideally to the modular concept. This system, briefly, encompasses the acquisition of a reliable data base from which a problem list is developed. From the problem list a plan evolves, borne out by relevant, concise progress notes. The progress notes themselves are structured to include the patient's subjective data, objective data, assessment of the problem and the plan to be followed. The plan of the progress notes includes an overview of the diagnosis, treatment, education and goal of each problem and the patient in general.

Inherent in this record system is the advantage of having everyone on the health care team write on the progress notes in the same problem oriented and problem solving manner.

Such a record is more easily understood and followed. It forces us to concentrate on each problem as it relates to the whole patient. It makes audit and review much easier. It is more accurate if done correctly. It is self-auditing and therefore self-teaching. It involves all medical disciplines that care for a patient in a structured, logically organized nonduplicating manner of medical care, planning and health care delivery. Audit and discipline, if needed, are performed by one's own peers in a dignified, in-hospital setting. This also requires a change that many will not accept. Like any record, if it is not accurate and updated, the individual record would be inadequate. To quote Weed: "Once you say to yourself that the medical record is the practice of medicine—and you agree to change the record, you change the reality that is medicine. And if you change the way you look at that reality, and you audit it, you change the reality that is a doctor."

In the November issue of the ASIM, Drs. Daines and Kanner[12] conclude: "Until enough clinicians can document clearly what they are doing, within the limits they have chosen to function—their skill in gathering data, their ability to recognize and define problems—the profession will be unable to put into effect any method of assessment and certification by performance and will be confronted with alternatives much less logical and acceptable."

Implementation

To implement such a system usually involves persuasion and education. Reference is made to the excellent Conference of Implementing "The Problem Oriented Medical Record" edited by Jay S. Wakefield and Stephen R. Yarnall.[6] First, don't do it alone! Explain and enlist members of an intelligent health care team. A suggested way

is to engage a small, unified department like an ICU, CCU or Cardiology Department. Provide literature, a brief lecture if necessary and allow adequate time for implementation. The word will spread and other departments will follow. It is not advisable to force the POMR on anyone. Many professionals are extremely resistant to change and honestly believe they cannot change. If the POMR succeeds in that department, or any department, it will succeed on its own merit.

It does not appear that a dictatorial approach to adopt this or any of the mentioned modular systems is satisfactory.

Continuing Medical Education

We have already seen the difficulty in setting up satisfactory eduactional programs for all. What appeals to one physician may not appeal to others. We have run the gamut of lectures, seminars, tutorials, auditing, audiovisual aids, etc. "Credits" are given for attending a course whether the student was there, mentally or physically. It has been said that in many conferences the notes of the lecturer have passed from his lips to the notebook of the learner without passing through the brain of either. It is suggested that the learner, as suggested by audit, pick those subjects in which he is most deficient and attain his "credits" in this manner. It is also suggested that the learner pick for himself the method by which he best learns.

On the job performance and education benefits everyone concerned with medical care. It is a much more practical system where accreditation is based on performance and patient care rather than recall. The arena of quality care is at the bedside and not on a multiple choice piece of paper. The feedback loop to and from medical audit and to the physician would provide the stimulus for CME.

Didactic lectures in a medical school setting appeal to many physicians. Yet, let us not forget that hypertension is a much more prominent, common and relevant disease than myxedema coma with all its classical textbook signs that we all know so well yet see so seldom.

The physician's (1) innate desire to further his knowledge, (2) his exposure and choice of differing educational opportunities offered in which he is active and possibly, in the future, a forced participant, and (3) the threat of being forced to collect "points" in order to retain his society membership, relicensure, and even certification should serve as motivation.[11]

PSRO

PSRO (Professional Standards Review Organization) is now a law whose purpose is to assure that payment for any government financial medical program will be made for services that only are a medical necessity.

The PSRO will have the legal right to examine the hospital records of any physician and may inspect his office records. Although this is the law, the regulations have not yet been written. The law empowers the HEW to designate these areas before January 1, 1974.[13] The PSRO is still vague but will involve at least 300 physicians, including osteopaths, to become eligible for an individual PSRO. Most likely this will involve state districts with local, state and government officials with a majority of physicians, preferably, on the panel with each PSRO district represented. The implications are plain, the law is clear, but the situation is not one to be feared if a constructive approach is taken quickly.

Summary

We have been put in a defensive position by society, politics, unfavorable publicity, and our own inertia. True, we have our faults and our weaknesses are under fire. We realize we do have problems. It is certain we can solve them in a pluralistic way. The methods suggested, in a modular way, are presented as a logical step involving our whole philosophy as physicians. The basic method is that of evaluation of Quality Care, Professional Audit, and Education to insure feedback to provide better health care delivery, and the spin off will be meaningful continuing medical education.

All of these problems are a real and serious challenge to our profession. They can be solved if we provide leadership as this opportunity is thrust at us.

Most states already have the machinery available. Peer Review has shown the effectiveness in controlling over-utilization. A foundation or corporation to provide a PSRO with responsibility to HEW would be the most likely link between the private hospital and the third party.

However, the basic modular premise would be that the hospital could and would be self-contained while performing its function in all the spheres mentioned. The state and national involvement and activity would stem from the PSRO districts with the hospitals initially at the core.

From the hospital discipline, outpatient services in the offices would follow where ten times the number of patients and health care delivery is provided. From this system a smooth working arrangement could evolve as long as we maintain our independence, leadership, and preserve our doctor-patient relationship.

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▶ Dr. St. Mary, 3661 South Miami Avenue, Mercy Hospital, Suite 506, Miami 33133.

Wording of New AMA Policy on PSRO

The new AMA policy on Professional Standards Review Organizations (PSROs), essentially a compendium of several different policies, reads as follows:

The AMA affirms the following principles:

1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and

2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and

3. That the association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality, and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public.

The considered opinion of the House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our longstanding policy and opposition to this legislation prior to passage.

The considered opinion of the Board of Trustees and the Council on Medical Service is to recommend to the House of Delegates that the AMA continue to exert its leadership, and support constructive amendments to the PSRO law, coupled with continuation of the effort to develop appropriate rules and regulations.

Principles of Parenteral Alimentation

John H. Seashore, M.D. and James L. Talbert, M.D.

Abstract: Parenteral alimentation is a new and valuable adjunct in the management of patients with severe gastrointestinal dysfunction. This paper reviews the metabolic background, techniques and complications of parenteral alimentation. Careful patient selection and strict adherence to basic principles will reduce the complication rate to an acceptable level. Control of the primary disease and early return to enteric feedings are of paramount importance.

The provision and maintenance of adequate nutrition is fundamental to the correction of most disease states. Adequate caloric intake can usually be accomplished by oral feedings. However, loss of gastrointestinal continuity and dysfunctional gut problems may preclude enteric feedings and lead to a progressive catabolic state or death from malnutrition.

Almost from the time Harvey discovered the circulation of blood, physicians have attempted to provide nutrients by vein. Infusions of wine, milk and other substances invariably failed to produce the desired effects. In the modern era, carbohydrates, protein, fat, and alcohol have all been utilized for parenteral feeding with variable but limited success.

Carbohydrate, usually glucose but occasionally fructose, xylose, or sorbitol, is the primary energy source in most intravenous solutions. Metabolism of carbohydrate yields approximately four calories per gram; standard intravenous solutions containing 5% carbohydrate yield 200 calories per liter. Solutions more concentrated than 10% (400 calories per liter) are so irritating that peripheral veins thrombose within a few hours.

Hydrolysates of fibrin and casein have been available for intravenous administration for nearly 40 years. A 2.5% to 5.0% solution provides sufficient protein to achieve positive nitrogen balance if sufficient nonprotein calories are available as an energy source to spare the nitrogen for tissue synthesis. A ration of 150 nonprotein calories per gram of nitrogen is optimal.

Fat, which yields 9 calories per gram when metabolized, is an obvious source of calories. Intravenous fat emulsions, which do not sclerose veins, were widely used in the 1940's and 1950's as a high calorie nutritional source, but their use has been abandoned in this country because of systemic toxicity characterized by fever, hepatic dysfunction and bone marrow depression.[1] A new fat emulsion which does not appear to have these problems is currently in use in Europe and undergoing clinical trials in the United States. A combination of fat, protein hydrolysate, and glucose can provide adequate calories and nitrogen in a tolerable fluid volume and can be administered through peripheral veins. If the European preparation proves to be safe, it will represent a great advance in the field of parenteral nutrition.

Intravenous ethyl alcohol is used in certain clinical conditions as an energy source. There are no good studies of the long-term effects of intravenous alcohol administration, particularly in large amounts for prolonged periods of time. Until such information is available, most clinicians are hesitant to use alcohol as the primary caloric source in intravenous nutrition.

It is apparent from these observations that the most concentrated solution available in this country for parenteral alimentation through peripheral veins provides only 600 calories/liter (10% carbohydrate, 5% protein hydrolysate). Consideration of average maximum tolerable intravenous fluid loads (4000 cc/24 hours in adults, 150 cc/kg/24 hours in infants) yields figures for maximal calorie intake of 2400 cals/24 hours in adults and 90 cals/kg/24 hours in infants. These levels are barely adequate for a patient in the basal metabolic state and are clearly insufficient for the patient who is already nutritionally depleted and has increased metabolic needs because of illness or injury.

In 1968, Wilmore and Dudrick reported a new technique for parenteral alimentation.[2,3] The

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crucial element of their method is the use of an intravenous catheter with the tip positioned in the superior vena cava. The high rate of blood flow and large lumen permit infusion of hypertonic dextrose with minimal risk of venous thrombosis. Using 20% to 25% percent dextrose with protein hydrolysate, minerals and vitamins, it is possible to infuse an adequate, total parenteral alimentation solution which, experimentally and clinically, has been demonstrated to produce positive nitrogen balance and, in children, growth and development.[2,5]

Indications

Major small bowel resections, enteric fistulas, far-advanced inflammatory bowel disease, and other overwhelming gastrointestinal disorders comprise the primary indications for hyperalimentation. These conditions preclude, or at least limit, effective oral alimentation in patients who are already nutritionally depleted. Newborn infants frequently require parenteral feeding even after relatively uncomplicated gastrointestinal surgery because they have limited nutritional reserves.

There are other conditions in which the indication for parenteral alimentation is less obvious but in which the added nutritional support may be decisive. Prolonged diarrhea in children can be a devastating problem, but with parenteral alimentation an anabolic state can be achieved and an orderly evaluation of the problem carried out.[6] In some cases, resting the gut for a few days or weeks may be curative even though a definitive diagnosis cannot be made. Patients with severe malnutrition from any cause may be too debilitated to take adequate oral nutrition and may require temporary intravenous alimentation.

Premature infants with respiratory distress syndrome, congenital heart disease, and other problems will often not tolerate sufficient volume of formula to meet their caloric needs. Several neonatal centers are investigating the effectiveness and safety of parenteral alimentation in achieving nutrition during critical growth periods.[7,8]

The severe and prolonged catabolic state associated with thermal burns is well known. These debilitated and depressed patients may be unable or unwilling to take sufficient oral feedings to meet their increased metabolic needs. Preliminary results of parenteral alimentation in these patients have been encouraging although the risk of sepsis is clearly increased.[9]

The complete spectrum of indications for parenteral alimentation has yet to be determined. Complications are not infrequent and may be fatal. A decision to begin parenteral alimentation must be carefully considered, based on a thorough appreciation of the patient's disease and an awareness of the benefits and dangers of the technique.

Techniques

Placement of the catheter must be considered as a surgical procedure with strict attention to asepsis. Personnel should wear mask and gloves. Good lighting, adequate assistance, and proper equipment are essential. With care and planning, the procedure may be done on the ward.

The catheter is placed so that its tip is in the superior vena cava. Any vein in the upper extremities or neck may be used. Percutaneous catheterization of the subclavian vein is widely used in adults and older children. In neonates we prefer direct cutdown on a jugular vein with placement of a radio-opaque Silastic catheter* which is softer and less reactive than polyethylene. Once the catheter is secured in the vein, the free end is tunnelled subcutaneously for four or five centimeters so that the exit site from the skin is remote from the venotomy to reduce transcutaneous contamination. The incision and catheter exit site are covered with iodophor† ointment and an occlusive sterile dressing. Careful fixation of the catheter to the skin with tape is essential to prevent inadvertent removal. Radiographs in the antero-posterior and lateral projections should be obtained promptly to confirm the catheter position since improper positioning of the catheter may cause a variety of complications (Fig. 1). The catheter tip should not be allowed to enter the right atrium.

Meticulous catheter care is essential for safe, prolonged catheterization. Every two days the area should be cleansed with an iodophor solution and fresh ointment and dressings applied. A closed infusion system should be maintained at all times to minimize contamination. The catheter should not be used to draw blood, and piggy-back infusions should never be used. Replacement of gastric or other fluid losses and administration of drugs should be through a separate intravenous line if at all possible. If a continuous flow is carefully maintained through the catheter, irrigation should not be necessary but if it is, strict aseptic technique should be used.

*Medical Products Division, Dow Corning Corp., Midland, Michigan 48640
†Betadine Ointment

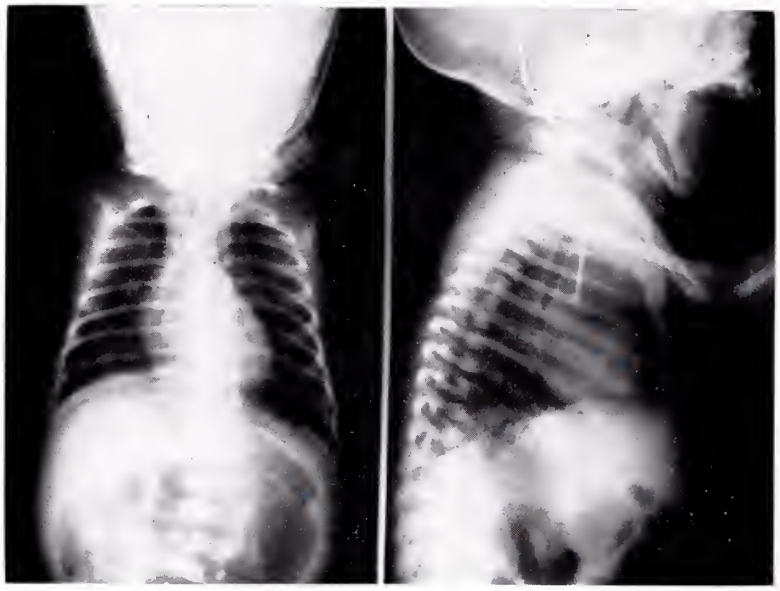

Fig. 1.—Radiographs of the chest showing proper position of the radio-opaque catheter at the junction of the superior vena cava with the right atrium.

A Millipore filter* should be inserted at the junction of the intravenous tubing with the catheter, except when administering blood or blood products which will occlude the filter. If an infusion pump is used, the 0.22 micron filter size may be employed; otherwise the 0.45 micron size is necessary to allow adequate drip rates. Tubing and filter are changed daily.

There are no established guidelines concerning the length of time a single catheter may be left in place. Considering the limited number of available sites, we do not change the catheter electively.

Preparation

Hydrolysates of casein or fibrin and mixtures of pure, synthetic 1-amino acids are commercially available for parenteral alimentation. All are effective and none has clear superiority. These preparations contain varying concentrations of protein and frequently have dextrose and minerals added. A portion of the solution is discarded and replaced with 50% dextrose, electrolytes, vitamins, and water to a total of 1000 cc to achieve the desired concentration of each of these elements. It is critically important to calculate the mixture properly and take into account the amount of dextrose and electrolyte already in the hydrolysate.

The parenteral alimentation solution currently in use on the Pediatric Surgical Service at the University of Florida is shown in Table 1. The contents of 650 ml of Amigen* (5% fibrin hydrolysate and 5% dextrose in water) are listed in Table 2, and the final concentration of each constituent in Table 3. At recommended rates of infusion, this mixture provides the average requirement of nutrients and minerals for infants and is adequate to achieve positive nitrogen balance. A copy of the list in Table 1 is placed on the patient's order sheet each day and appropriate changes made by crossing out the printed amounts and writing in the desired quantity. For example, a patient with hypokalemia may require additional potassium. Adults usually require slightly more sodium and potassium, considerably less calcium and magnesium, and vitamins in only one liter of each day's total infusion.

Careful mixing of the parenteral alimentation solution is critical, both to assure proper constitution and to reduce the risk of contamination. Infection is the most common and dangerous complication of parenteral alimentation and the fluid is an excellent culture medium. Ideally, it should be mixed in the pharmacy department by trained personnel using laminar-flow hoods and sterile equipment. It should never be mixed at the bedside and nothing should be added once the bottle is prepared. Once the solution is mixed, it should

*Millipore Corporation, Bedford, Massachusetts

*Baxter Laboratories, Morton Grove, Illinois

Table 1.—Parenteral Alimentation Mixture For Infants.

Amigen	650 cc
50% Dextrose	335 cc (167.5 gms)
Sterile Water	0 cc
NaCl	3 mEq
KCl	13 mEq
Ca Gluconate 10%	19 cc (8.5 mEq Ca++)
Mg Sulfate 10%	3.0 cc (5.0 mEq Mg++)
MVI	1 ampoule
Aquamephyton	0.2 mg
Vitamin B_{12}	6.6 mcg
Folic Acid	0.5 mg
	1000 cc

Table 2.—Contents of 650 cc 5% Amigen in 5% Dextrose.

	Per Liter	Per 650 cc
Protein (casein hydrolysate)	50 gm	32.5 gm
Dextrose	50 gm	32.5 gm
Na+	35 mEq	23 mEq
K+	19 mEq	12 mEq
Ca++	5 mEq	3.2 mEq
Mg++	2 mEq	1.3 mEq
Cl—	20 mEq	13 mEq
HPO4—	30 mEq	19.5 mEq

Table 3.—Contents of 1 Liter of Parenteral Alimentation Solution.

Protein	32.5 gm	130 cals.
Dextrose	200 gm (167.5 + 32.5)	800 cals.
Sodium	26 mEq (23 + 3)	
Potassium	25 mEq (12 + 13)	
Chloride	29 mEq (13 + 3 + 13)	
Calcium	11.7 mEq (3.2 + 8.5)	
Magnesium	6.3 mEq (1.3 + 5.0)	
Phosphate	19.5 mEq	
		930 cals.

be refrigerated until used and should not be kept longer than 24 hours.

Administration

In neonates, the recommended rate of administration is 135 ml/kg/day which provides 123 cals/kg/day. Larger volumes may be tolerated if additional calories are deemed advisable. In adults, two or three liters a day are usually tolerated.

Many patients, especially neonates, will not tolerate the high (20%) concentration of glucose at first, and it is advisable to start with a "half-strength" solution. Only the glucose needs to be reduced. The sterile water is correspondingly increased to maintain the same concentration of other components (Table 4). Glucose concentration can be advanced to full strength over a few days as indicated by normal blood sugars and absence of glycosuria. Some premature infants are unable to utilize all of the infused protein and develop generalized aminoaciduria with subsequent osmotic diuresis and dehydration.[8] In such patients it may be necessary to reduce the protein concentration of the infusate to 2% or less by reducing the base volume of hydrolysate and recalculating the additives.

The parenteral alimentation solution previously described provides all known nutrients except fatty acids, iron and trace minerals. Requirements of trace minerals are unknown, but it is becoming increasingly clear that deficiencies do develop during prolonged parenteral feeding.[10] Weekly infusions of plasma or whole blood should be administered to provide essential fatty acids and at least some trace minerals. Iron requirements can be supplied as whole blood transfusions or by intramuscular iron-dextran.

Monitoring

Patients receiving parenteral alimentation must be carefully monitored. Urine sugar and specific gravity should be checked at least three times a day, and urine output measured carefully. Daily measurement of body weight and frequent examination of the patient for skin turgor, fullness of fontanelles, and level of activity are helpful in assessing the state of hydration. Frequent hematocrit and serum solids determinations are of value to follow nutritional improvement and as reliable indicators of sudden fluid shifts. Blood sugar, urea nitrogen and electrolytes should be checked daily until stable, then at regular intervals. Serum levels of calcium, phosphorous, and magnesium should be measured weekly. A flow sheet of laboratory parameters is helpful.

Constant alertness for clinical signs of infection is important. Urine cultures may become positive, especially with Candida, before sepsis is manifest clinically and should be obtained twice a week. Blood cultures should be obtained once a week and any time there is suspicion of sepsis.

Table 4.—Illustrative Calculations for Solutions Containing Less Dextrose.

"Half-strength"	
650 ml Amigen	= 32.5 gm dextrose
135 ml D50W	= 67.5 gm dextrose
200 ml sterile water	
	100.0 gm dextrose/L = 10%
"Three-quarter strength"	
650 ml Amigen	= 32.5 gm dextrose
235 ml D50W	= 117.5 gm dextrose
100 ml sterile water	
	150.0 gm dextrose/L = 15%

Note that the volume of sterile water varies inversely with the volume of D50W in order to maintain the same concentration of other additives.

Complications

Parenteral alimentation is not a benign technique. Complications are frequent and may be fatal. Thorough understanding of the potential complications and strict adherence to a carefully planned protocol are essential to the safe use of this technique.

Infectious Complications. The most common and dangerous complication is infection. The presence of a percutaneous foreign body in the vascular system may not only provide a portal of entry for microorganisms but may serve as a nidus for the growth of bacteria entering the blood stream from other sources. Parenteral alimentation solutions have been demonstrated to be excellent media for growth of bacteria and fungi.[11] Gram-positive and gram-negative bacteria are encountered frequently, but it is becoming increasingly clear that fungal sepsis, particularly with Candida, is the major problem.[11-14] Candida organisms are common contaminants of skin, oral cavity in babies, and the vagina in adult women. Debilitating illness and broad-spectrum antibiotic therapy predispose to fungal infection, and venous catheters readily support continued growth of Candida once it has entered the blood stream.

Sepsis may become manifest in the classical manner with fever, chills, and elevated white blood cell count, but more often presents with subtle signs, especially in neonates, Lethargy, poor color, or failure to gain weight despite adequate intake may be the only indication of developing blood stream infection. Sudden onset of glycosuria has been a reliable indicator of sepsis.[15] In any patient, septic shock may develop.

The incidence of infectious complications in most series ranges from 10% to 65%.[8,11,16] Candida is the offending organism in one third to one half of cases. Mortality in infected patients has been 10% to 80%.[11-14] These patients usually have multiple problems and it is not always clear whether infection is the primary cause of death.

There is a definite relationship of infection to duration of catheterization.[13] Sepsis is rare in the first week and relatively uncommon for two to three weeks. Thereafter, the incidence rises sharply. Obviously, every effort should be made to correct the patient's underlying disorder and terminate parenteral alimentation as soon as possible.

Strict adherence to the principles of catheter placement and care, aseptic preparation of solutions, and maintenance of a closed administration system should reduce the incidence of catheter-induced sepsis to 3% to 4%.[17-19] It is an unavoidable fact that many patients who require parenteral alimentation have wound infections, peritonitis, pneumonia, or urinary tract infection, and efforts to control these infections will reduce the probability of septicemia and secondary infection of the catheter.

Fortunately, most episodes of sepsis, particularly those due to Candida, respond to removal of the catheter if this is done promptly before metastatic infection of distant organs has occurred.[12] If cultures remain positive after removal of the catheter, specific antibacterial or antifungal therapy is indicated. Prophylactic antibiotics have no value whatever, and specific therapy without removal of the catheter is rarely successful.

Catheter Complications. Reported complications due to the catheter include cardiac arrhythmias, perforation of major veins with infusion of fluid into the pleural space or mediastinum, and perforation of the heart with pericardial tamponade and death.[14,20] These are almost entirely preventable if the position of the catheter tip is confirmed by x-ray.

Thrombosis of the superior vena cava or major tributaries has been reported.[14,21] It is uncommon and usually resolves within a few days to two weeks after removal of the catheter. If the clot is infected, however, permanent sequelae and death may result.

Metabolic Complications. Infusion of a complex hypertonic solution imposes a metabolic burden on the patient and an even greater burden on the responsible physician to be certain that the patient's homeostatic mechanisms are not overwhelmed.

Osmotic diuresis producing hypertonic dehydration is the most predictable metabolic complication of parenteral alimentation. If the pancreas is unable to produce enough insulin to utilize fully the infused glucose, osmotic diuresis will ensue. As noted, this is a commonplace occurrence in the first day or two of therapy, and it is wise to start with smaller concentrations of glucose and increase gradually as the pancreas adapts. If this approach is used, the addition of exogenous insulin is rarely necessary.

Most patients will have occasional glycosuria of 1+ or 2+ and normal or slightly elevated blood sugar levels. Balance studies have shown that despite occasional spillage, 99% of the infused glucose is metabolized.[5,7] Intermittent glycosuria and high urine specific gravity do not necessarily prove that the patient is experiencing osmotic diuresis and do not usually require treatment.

Persistent glycosuria of 2+ or higher demands immediate investigation. Clinical signs of dehydration, high blood glucose, and increased urine output all suggest hyperosmolar dehydration. The glucose content of the infusate should be reduced or supplemental insulin given. If the glycosuria appears suddenly in a patient who has previously tolerated the infusion, sepsis should be considered.

Some patients, particularly premature infants, are unable to utilize the usual amount of protein and may develop osmotic diuresis secondary to generalized aminoaciduria. Poor weight gain, dehydration, high specific gravity, increased urine output, and absence of glycosuria should suggest this diagnosis. The dipstick method for estimating proteinuria will not detect amino acids. If facilities are available for quantitative amino acid determination, the aminoaciduria can be documented and its disappearance monitored as the protein content of the infusate is decreased.

Dehydration in a patient on parenteral alimentation is not always a result of osmotic diuresis. Excess fluid loss from the gut or the respiratory tract or sequestration of fluid in a third space will be manifest by dehydration and decreased urine output, usually without glycosuria. Increasing the rate of infusion or replacing the excess losses with appropriate fluids through a separate peripheral intravenous line will resolve this problem.

Blood glucose and insulin production are delicately balanced, but insulin production tends to lag behind the glucose load presented to the body. To avoid wide fluctuations in blood glucose levels and glycosuria, it is important that the hypertonic glucose be infused at a steady rate throughout each 24-hour period. Sudden termination of the infusion may produce profound symptomatic hypoglycemia. Glucose concentration should be reduced to 10% for about 12 hours before discontinuing therapy.

Metabolic acidosis occurs in some patients on parenteral alimentation. All of the protein solutions have a high titratable acidity and an even higher potential acid load which is released as the amino acids are metabolized.[22,23] The synthetic amino acid preparations are particularly acidogenic since many of the amino acids are present as the hydrochloride salt. Buffering the solution is of little value and may produce precipitation since the calcium content of the final mixture is quite high. Significant acidosis is fortunately unusual. It is best treated by temporarily stopping the parenteral alimentation mixture and infusing 10% dextrose and sodium bicarbonate. If the patient is able to take anything by mouth, oral sodium bicarbonate may be effective.

Fibrin hydrolysates and synthetic amino acid preparations contain no phosphate and their use may lead to significant hypophosphatemia.[24] This problem can be avoided by adding part of the potassium as the phosphate rather than the chloride. If too much phosphate is added, calcium phosphate precipitation may be encountered.

Vitamin deficiencies will occur if vitamins are omitted from the infusion. MVI* is the only available intravenous vitamin preparation which contains vitamins A and D as well as the water soluble vitamins. Trace mineral deficiencies have been discussed and will undoubtedly continue to be a problem until it is possible to add appropriate specific quantities of copper, manganese, and so forth.

Jaundice, hyperammonemia and other abnormalities of liver function have been reported.[25,28] These are usually transient and may resolve even without discontinuing parenteral alimentation. The cause of these derangements is generally unknown but may be related to an excess or deficiency of certain amino acids. Periodic monitoring of liver function is advisable.

References are available from the authors upon request.

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*Multi-Vitamin Infusion, USV Pharmaceutical Corp., Tuckahoe, N.Y.

Kindness consists of liking people more than they deserve.

Reversed Intestinal Segments in Treatment of Postgastrectomy Syndromes

Case Report

Frank Fidei, M.D. and W. R. Rundles, M.D.

Abstract: One therapeutic modality is presented for treating the "gastric cripple." Because of wasting from their disease, surgery on these patients is technically easy and gratifying. A period of preoperative hyperalimentation is not only suggested, but is probably a requisite to a good surgical result.

The literature is replete with accounts of problems following gastric surgery.[1] Herrington[2] describes six distinct syndromes that compose the larger category of postgastrectomy syndrome. Two of these syndromes, dumping and postvagotomy diarrhea, are pertinent to the current case report. Because of the relative paucity of recent literature on remedial operations for these syndromes, we feel that our experience is worthy of report.

Case Report

The patient, a 52-year-old white female, was admitted to Sacred Heart Hospital of Pensacola in September 1971 with a six month history of epigastric discomfort and burning unrelated to the presence or type of food ingested. She had no abdominal symptoms prior to that time nor gastrointestinal bleeding. She had been constipated with a formed bowel movement every two to three days. She was a small woman with a stable weight of 108-110 pounds. Gallbladder series showed a solitary gallstone. Upper G.I. series showed three distinct large ulcers in the distal stomach, the largest measuring 2x2½ cm. Laboratory data were unremarkable except for high gastric acids that could be increased fourfold with histalog stimulation.

Because of the high acid level and multiplicity of gastric ulcers, she underwent antrectomy (approximately 40% gastric resection) with Billroth I anastomosis in addition to truncal vagotomy and cholecystectomy. Postoperatively, she recovered well from surgery and was free of pain and discomfort. Soon however, disabling diarrhea developed with weight loss. Six months postoperatively her weight was 89 pounds and still falling. The diarrhea was not particularly voluminous.

Approximately six weeks after surgery upper G.I. series showed a normal esophagus and no hiatus hernia. The stomach emptied at an exceedingly rapid rate. Ingested barium passed through the stomach in a matter of seconds and the motility of the small bowel was rather rapid. The barium was given in several increments during the procedure but most of the barium given was in the mid to lower small bowel in a matter of one to two minutes. On a 30 minute follow up film the opaque material had reached the colon. There was no evidence of marginal ulcer.

She was treated intensively by a gastroenterologist both in and out of the hospital but continued to have severe dumping and diarrhea. Colon pathology again was ruled out by sigmoidoscopy and barium enema.

Six months after initial surgery the patient was readmitted. She received parenteral hyperalimentation according to Dudrick's[3] regimen for two weeks with an eight pound weight gain. On 4/19/72 she underwent laparotomy and jejunal reversal as follows:

PROCEDURE: The abdominal cavity was entered by a right paramedian rectus retracting incision. The ligament of Treitz was identified and a distance of 36 inches was measured on the antimesenteric border of the intestine. Beginning at this point for a further distance of 6 inches the jejunum was divided. The mesentery was then incised and as few vessels as possible were ligated so as to permit this 6 inch segment of jejunum to have an intact vascular pedicle. The mesentery was divided for a distance of about 2½ inches from the intestinal wall and the intestine rotated 180 degrees in a counter-clockwise manner.[4-6] Then a standard two layer open anastamosis was done twice, restructuring the continuity of the small bowel with the 6 inch section reversed. Each anastamosis was palpated and found to have an adequate lumen. The vascularity of this segment of intestine was good with visible pulsations. The intestine was of good color and peristalsis was noted to be in a retrograde manner, that is, opposite the previous direction of peristalsis. The defect in the mesentery was reapproximated. The viscera and the extremely small omentum were then returned to their normal position and the abdominal wall was closed in layers. The operative procedure was short and technically easy in this thin patient.

The postoperative course was uncomplicated. She left the hospital on the 10th postoperative day. Following this procedure the patient had cramping pain with meals for approximately two months and had an occasional dumping episode. By the third postoperative month weight gain up to 103 pounds had taken place, there was no further dumping or diarrhea and in fact the patient had mild constipation. Four months postoperative by x-ray she still had rapid emptying of the stomach but small bowel pattern was normal. Fourteen months postoperative weight gain up to 110 pounds had occurred and she is well pleased with the result. She is back to her normal weight and occasionally has to take something for constipation.

Discussion

Some diminution of diarrhea has been reported by the advocates of selective vagotomy,[7] but the problem of diarrhea has not been eliminated.[8]

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Most patients with diarrhea following gastric surgery either require no therapy or only mild medical management. It is in the smaller severe diarrhea group of "gastric cripples" that remedial surgery may be required. There are many alternatives to this procedure that can be used depending upon the surgeon's preference and whether dumping, a small gastric pouch or the vagotomy is at fault. These are all well illustrated in Herrington's monograph on the subject.[1] Careful case selection is required as neuroses, intrinsic small bowel disease and many other factors can be responsible for the syndromes. These procedures are also useful in diarrhea following massive small bowel resection and right hemicolectomy.

Summary

Review of the literature and this case report indicate that help is available to certain "gastric cripples" through the definitive surgical procedure described. Further usage of similar procedures is advocated for various surgically induced diarrhea states. The procedure was curative in this patient. Even when not curative, these procedures are often markedly beneficial.

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The Killers—Cancer

PBS-TV—March 11

8:00 p.m. - 9:30 p.m.

Cancer will strike one out of every four Americans at some time during his or her life. It is the nation's second largest killer.

The National Cancer Act of 1971 set the stage for what was promised as a "billion dollar fight to conquer cancer." Whereas many individuals held out great hope for a "quick cure," cancer specialists are far more cautious. The unhappy truth is that over 60 percent of people afflicted with cancer—excluding that of the skin—die from it. Almost half of all women who get breast cancer will die from the disease; the fatality rate is approximately 50 percent for men and women who have oral cancer as well as cancer of the kidney or bladder. Virtually everyone who gets stomach cancer dies from this dread disease, and the survival rate is only 9 percent for those afflicted with lung cancer.

In the area of prevention, scientists are looking at the environment, at food, and at hereditary disposition toward certain tumors. At the basic research level, they are probing the character of the tumor cell to find out why it grows out of control and are stepping up the search for elusive viruses that are suspected of causing some human tumors.

Combination drug therapy, while holding out hope, seems to work best only in the hands of a few specialists. Centers for cancer treatment now need to be spread across the country so that more people will have easier access to the best—and latest—therapy, in the hands of experts. Fifteen cancer centers are slated to go into operation around the country by 1975, but there is much more to be done.

Practicing physicians need to know more about who the experts are; individuals need to seek means for early detection; and communities must look into environmental causes. These are among the subjects covered on the Cancer show in "The Killers" series.

Watch for this program on your local PBS-TV.

Time and date may vary locally.

Intrarectal Tear With Bleeding From Water Skiing Accident

John R. Ramey, M.D.

I was called to the emergency room on Saturday, June 30, to see a 23-year-old girl with rectal bleeding. She reported she had fallen while water skiing and hitting the water her bikini bathing suit had pulled to one side of the perineum. She felt sudden pressure in the lower abdominal and rectal area, followed by some cramping in the left lower quadrant. Going ashore she noticed some bleeding but paid little attention at first because of her menstrual period. She discovered later, however, that the bleeding was from the rectum.

The past history revealed one pregnancy at age 20 and no previous surgery.

There was slight tenderness in the lower abdominal region with no rigidity and normal bowel sounds. Examination with anoscope and proctoscope revealed what appeared to be a superficial tear beginning in the rectum about 4 cm above the anus and extending superiorly on the anterior wall for about 4.5 cm. Bleeding was of mild to moderate amount. Sutures appeared unnecessary and unwise, therefore, the rectum was packed with 2 inch vaginal packing. The anal sphincter appeared quite relaxed.

She was admitted to the hospital and started on oral doxycycline hyclate.

During the night bleeding began around the packing and two transfusions were given. On Sunday morning she was still bleeding but there were no signs or symptoms of excessive blood loss. A Foley catheter was inserted because of inability to void. Bimanual examination revealed some induration around the paracervical tissues suggesting occurrence of ecchymosis around the base of the bladder which may have accounted for the inability to void.

She was taken to the operating room and under general anesthesia placed in the jacknife position. When the buttocks were pulled apart with tapes, the anus gaped for a diameter of at least 2.5 cm. It was easy to insert a retractor and visualize a tear which began about 4 cm above the anal verge and extended cephalad for about 6 cm. The tear extended through all layers of the rectum on the anterior wall, down to but not through the vaginal mucosa. The wound was closed with interrupted chromic catgut which controlled the bleeding.

The scope was passed for a distance of 8 inches and no other injuries were observed. Following surgery she was given oral doxycycline hyclate and intramuscular kanamycin sulfate. No fever occurred and she had a normal bowel movement on the fourth postoperative day. Other than temporary inability to void, she had no difficulties and was discharged from the hospital five days postoperatively.

She was seen again on July 12 and reported no pain or bleeding and no bowel or urinary problems. Digital examination revealed no abnormalities. On separating the buttocks, the anus gaped open for about 2 cm. Proctoscopy revealed the sutured area to be healing well. She has had no difficulty with bowel control in the past or since surgery.

In this case the important factors appear to be the wearing of a bikini bathing suit while water skiing and laxity of the anal sphincter which allowed a stream of water at an excessive pressure to enter the rectum, ballooning it and exploding it along the anterior wall.

My colleagues and I have never heard of a similar case and we thought it worthy of report.

▶ Dr. Ramey, 8037 Northeast 2nd Avenue, Miami 33138.

Sign of a cold sufferer

Time for Ornade®

Each capsule contains 8 mg. Teldrin®
(brand of chlorpheniramine maleate);
50 mg. phenylpropanolamine hydrochloride;
2.5 mg. isopropamide, as the iodide.

Fast relief of upper respiratory congestion and hypersecretion with convenient b.i.d. dosage.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

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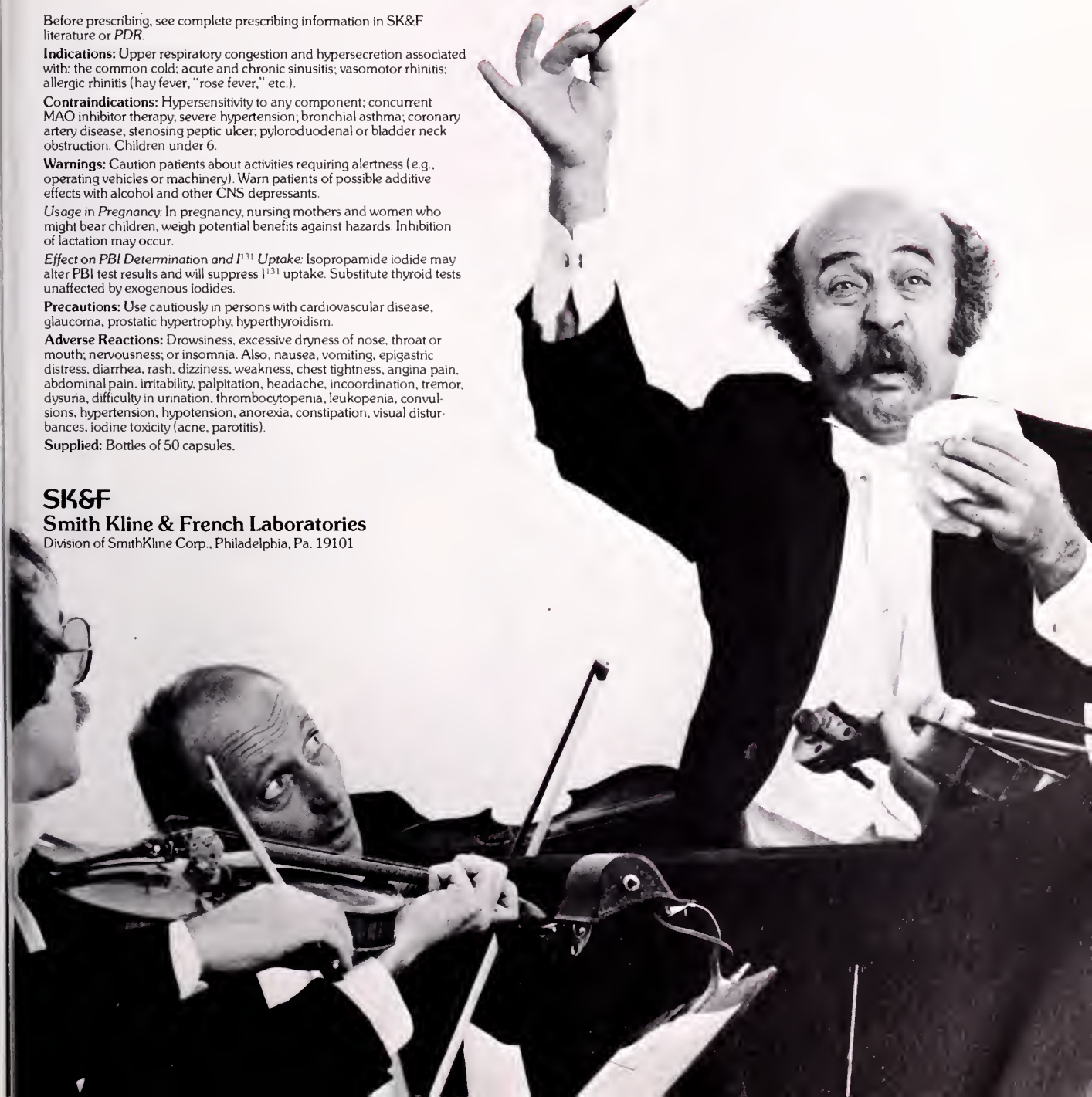
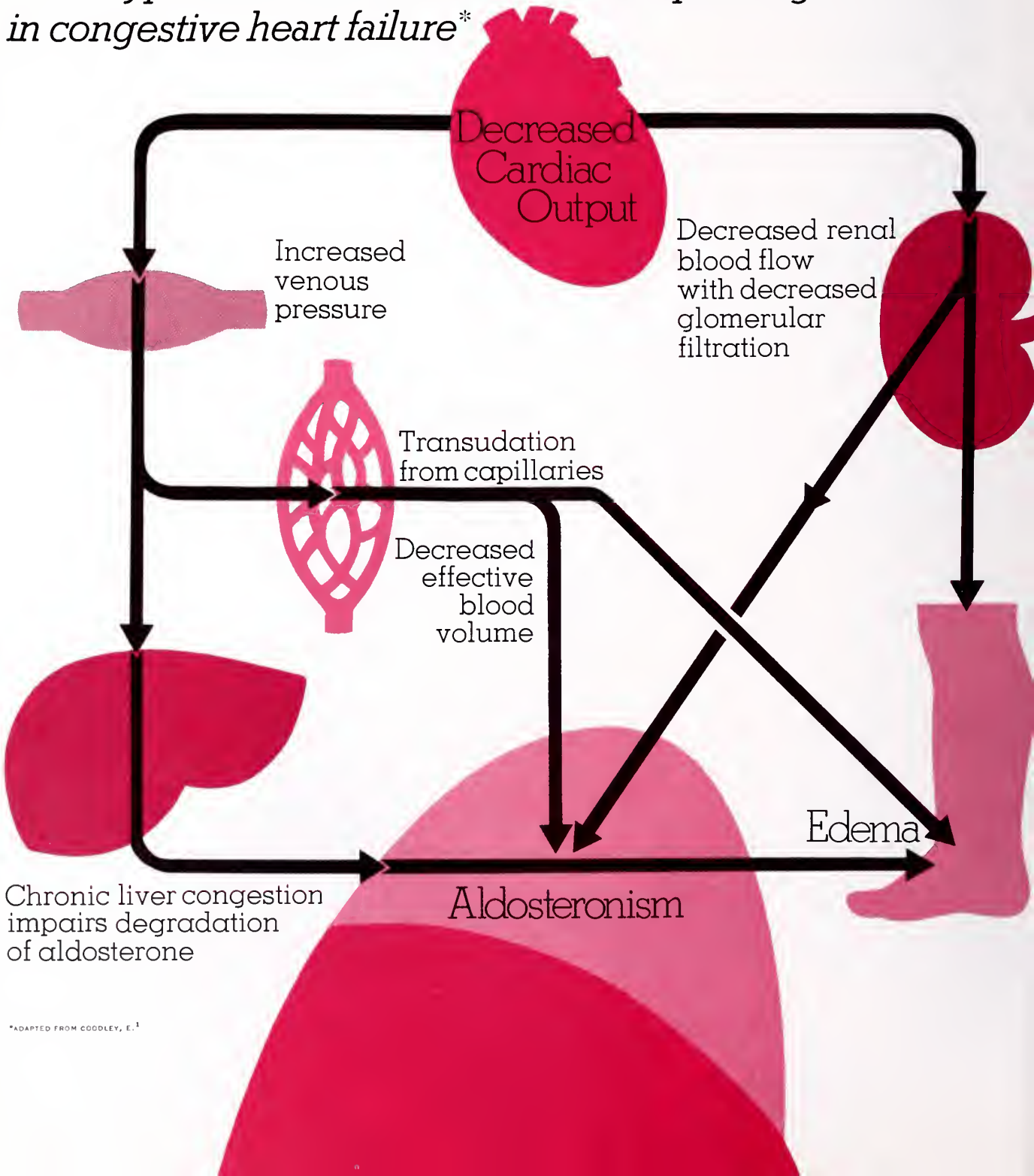


In congestive heart failure...

secondary aldosteronism

*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**



*ADAPTED FROM GOODLEY, E.[1]

is a primary factor

To "switch off" the aldosterone factor in congestive heart failure

Aldactone®

brand of

spironolactone 25-mg. tablets

the only specific aldosterone antagonist... basic in all diuretic therapy

Three ways to use Aldactone in congestive heart failure

1. As the only diuretic

- Often sufficient alone.
- Produces gradual, sustained diuresis by blocking aldosterone action in the distal renal tubule.
- Avoids potassium loss.

2. As the basic daily diuretic with an "add-on" alternate-day-diuretic ("A.D.D." schedule)

- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E. Consultant 12 106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P. Am. J. Med. 53 673-684 (Nov.) 1972.

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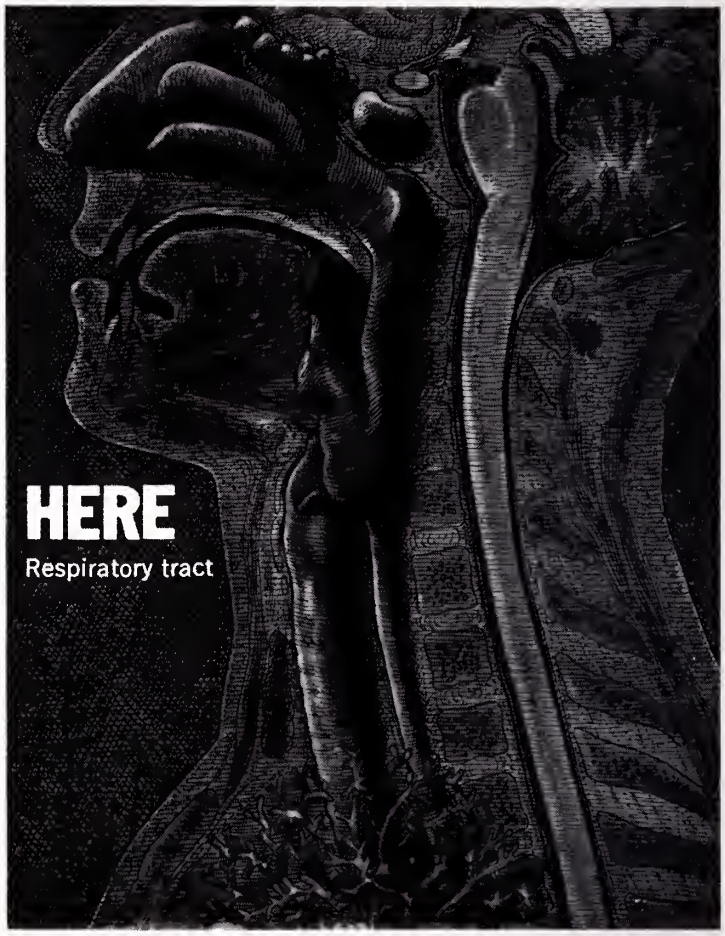

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Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
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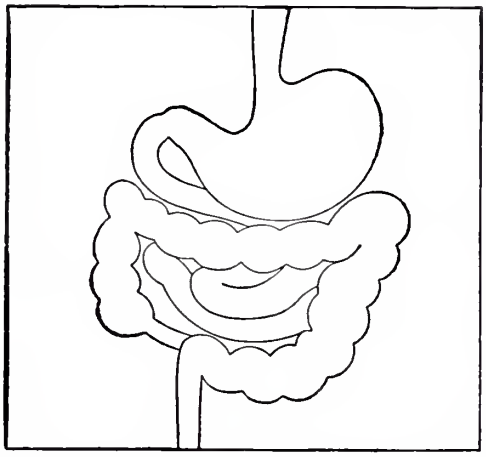
in "Gasspastic" conditions



The GI tract in spasm is commonly a "gas trap."

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In addition to the traditional combination of belladonna alkaloids and butabarbital (warning: may be habit forming.), Sidonna contains simethicone—a non-systemic defoaming agent that "lyses" gas bubbles on contact.

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Each scored tablet contains: Specially activated simethicone 25 mg.; hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: May be habit forming.)

can do more

Contraindications: Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.
Side Effects: Dryness of the mouth, blurred vision, dysuria, skin rash, constipation or drowsiness may occur.

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Editorials

Why PSRO?

A report to the U.S. Senate Committee on Finance revealed that the cost of the Medicare hospital insurance program will over-run the 1967 estimates by $240 billion in a 25-year period. These increases in cost were attributed to an increase in the unit cost of services, (physician visits, surgical procedures and hospital days) and an increase in the number of services provided to beneficiaries. The committee, looking for means of reducing costs and being told that a significant proportion of the health services provided were probably not medically necessary, reached the conclusion that the present system of assuring proper utilization of institutional and physician services was basically inadequate. Blaming not only the private practice of medicine but the existing bureaucracy for failing to enforce the quality of care standards that existed, the PSRO amendment was passed by congress without debate. Saying that the demands for accountability issued by society to those who serve it have become a symbol of our times, Washington continues to defend the law. And based on a conclusion that the federal government alone does not have the ability necessary to make the judgment how $17 billion of taxpayers' money for health care is spent yearly, the medical profession has been told to give accountability in a consistent fashion. Simplified, this means that a list of standard diagnostic and therapeutic procedures is compiled for each disease. Average hospital stays for each are estimated. Computers are programmed with this data. Chart summaries prepared by medical librarians are fed into the computer. Any record that fails to meet the standards is reviewed by a team of physicians. Improper utilization is to be detected and used somehow for future reduction of costs. Care will be standardized but will it cost less?

Should standards be set by specialty societies, they would be pegged to methods of practice which run to the unusual case, which to investigate, requires a depth that does not apply to the bulk of medical problems. Commendable for this type of practice, it would be a financial disaster if applied to the ordinary cases. For instance, take the diagnosis of headache. Standards of treatment set by a neurologist would require arteriograms, encephalograms, x-rays of the skull, sinuses and cervical spine, electroencephalograms and brain scans. Yet, for 90% of these patients, the taking of a careful history and a physical examination will reveal the diagnosis. However, to follow the standards set by the specialists, this would not conform, but should every practitioner conform, expenditures will skyrocket. Extend this example to every disease and entity. Consider those bizarre cases that fit no diagnostic category and end up with no ascertainable biological basis of any disease being present, or those patients with multiple pathology such as the elderly person with coronary artery disease, diabetes mellitus, pulmonary emphysema, osteoporosis, etc. Another dilemma would be the original thinker who has different ideas about diagnosis and treatments and who makes many of the advances in medical care. He will be so busy defending his unorthodox methods that he will never get anything done. Then there would be the physician who looks up the rules in the book, follows them, and does the same thing every time. He won't have to think, and he can beat the system without really working at it.

There is no sure way to catch the bad apple. All he has to do is describe some textbook symptoms, and order the standard tests appropriate for that disease. His diagnosis may be wrong, his studies inappropriate but the computer will never know and his charts and his results will never be reviewed. On the other hand, sufficiently wise to make a diagnosis without subjecting their patients to all the procedures the less skilled find

necessary, many doctors omit things that standard makers may consider essential. Yet, when PSRO's are widely implemented, will not these doctors be forced to do all these extra things? How can this result in anything but increased cost?

PSRO's are being sold as a mechanism for insuring quality care and full value for the health dollar. Utilization review saves money by reducing services. Standard setting increases costs by creating a minimum standard which may be unnecessary. Will the patient, "the health care consumer," be happy either way? If the PSRO is a workable concept, there is available in Washington a program to assist in making this decision. This is EMCRO (Experimental Medical Care Review Organizations) a pilot study that could be used to help determine whether PSRO will work. There is need for an effective peer review system that can identify and correct substandard, unnecessary and inappropriate care. To develop such a system, we need only follow a resolution of the House of Delegates of the AMA, "to abet local hospital staff committees to work with local medical societies to develop an unassailable inhouse review program to ward off direct nonmedical intrusion."

At the December AMA Clinical Convention, the House of Delegates heard Rep. Phillip Crane, who is leading an effort to repeal the PSRO law, say the law would let bureaucrats impinge their judgments on doctors' decisions and destroy the confidentiality of patients' records. They then voted overwhelmingly to seek repeal, but recognizing slim prospects for such action, stopped short of total noncooperation. At the same time, the delegates asked that while we continue to exert leadership in implementing the PSRO law, we should do all in our power to inform the public and legislators of the law's deleterious effects on the quality, confidentiality and cost of medical care.

Described as "a wasting disease, insidious, destructive, demeaning and degrading," if this is true and deleterious to the public, our patients; it behooves us to mobilize our best intellects, ferret out the causes of this malady and determine how best to eradicate it.

C.M.C.

Lest We Become Victims of Our Own Groupthink

Do you have fixed ideas on PSRO? Have you omitted examination of readily available data? Do the groups in which you participate and the publications you read present only one point of view and deride other points of view?

If the answer to any of these questions is yes, then you may become a victim of your own groupthink.

Irving Janis,* in his recent book, presents an interesting point of view in which he gives examples of groupthink in government. One of the examples is the Bay of Pigs crisis which beset President Kennedy's administration shortly after the inauguration. Persons participating in high level meetings were more concerned about group acceptance and how their remarks would be received by their hearers rather than a search for the wisest course. He also described how Secretary of State Dean Rusk acted as a "mind guard" to prohibit the President from receiving information which Rusk himself considered to be "adverse and confusing." Consequently, in a closed group, reinforcing a preconceived point of view, a small group excluded readily available data which, on reflection, would have led to different conclusion and a different course of action. The rest is history and known to each reader. The ill-fated Bay of Pigs invasion was a complete failure, an embarrassment to the administration, and was one factor which led to the brink of nuclear war with the Cuban missile crisis.

This editorial is a plea for rational consideration of all the evidence (on PSRO), consideration of the alternatives for action, and possible counter reaction from other groups such as HEW, insurance companies, nurses' organizations, and labor unions.

The ideals for medicine which we cherish may still be doomed. Rational courses of action may not always be successful; however, groupthink as defined by Janis is almost always destined for failure.

F. N. V.

**Victims of Groupthink* by Irving L. Janis, Houghton-Mifflin Company, Boston, 1972, Price $7.95.

PSRO

PSRO will soon be looming bigger and bigger on the medical horizon and it behooves us all to take a good hard look, straight and without preconceptions. The AMA House of Delegates support constructive amendments to the law . . . and affirms a commitment to the principle of peer review under professional direction . . . through how many mouths can the AMA speak! . . . On the state level, a Florida Professional Standards Review Organization was registered with the Secretary of State on June 21, 1973. Reading the latest copy of the Articles of Incorporation and By-Laws indicates that its affairs will be governed by a Board of Trustees whose term of office is not fixed . . . and who will be joined by a representative from each local PSRO in accordance with procedures to be specified by the Board and may be altered or amended only by it . . . Offering THAT kind of expertise it proposes to advise and to guide you from far away, rather than to use know-how every bit as good near at hand under local control . . . Let the state organization be a resource center to supply technical and supportive help and to be the next higher level of appeal. . . . The West Florida instrument proposes that physicians in the local medical service area shall accept the responsibility and authority to establish their own peer review mechanism and parameters of care, allowing every doctor to identify with and to participate in the review process, an organization which can be reached by a local phone call for resolution of a problem, with built-in protection of confidentiality and severe penalties if violated . . . accepting peer review by the various hospital Utilization Review Committees whenever the local PSRO finds that such review is effective and involves all the hospital staff; actually the PSRO program only establishes LOCALLY developed and accepted medical check points, not arbitrary indices . . . choice of physician remains free and each local PSRO establishes its own profiles of patients and care. When best medical care is menaced and the patient's welfare is threatened, the local PSRO will withdraw. Rather than considering PSRO as the fox in the chicken coop, think of it as a rooster says CHIT and CHAT. Are you listening out there?

NATHAN S. RUBIN, M.D.
PENSACOLA

Reprinted from "Chit and Chat," Escambia County Medical Society Bulletin, January 1974.

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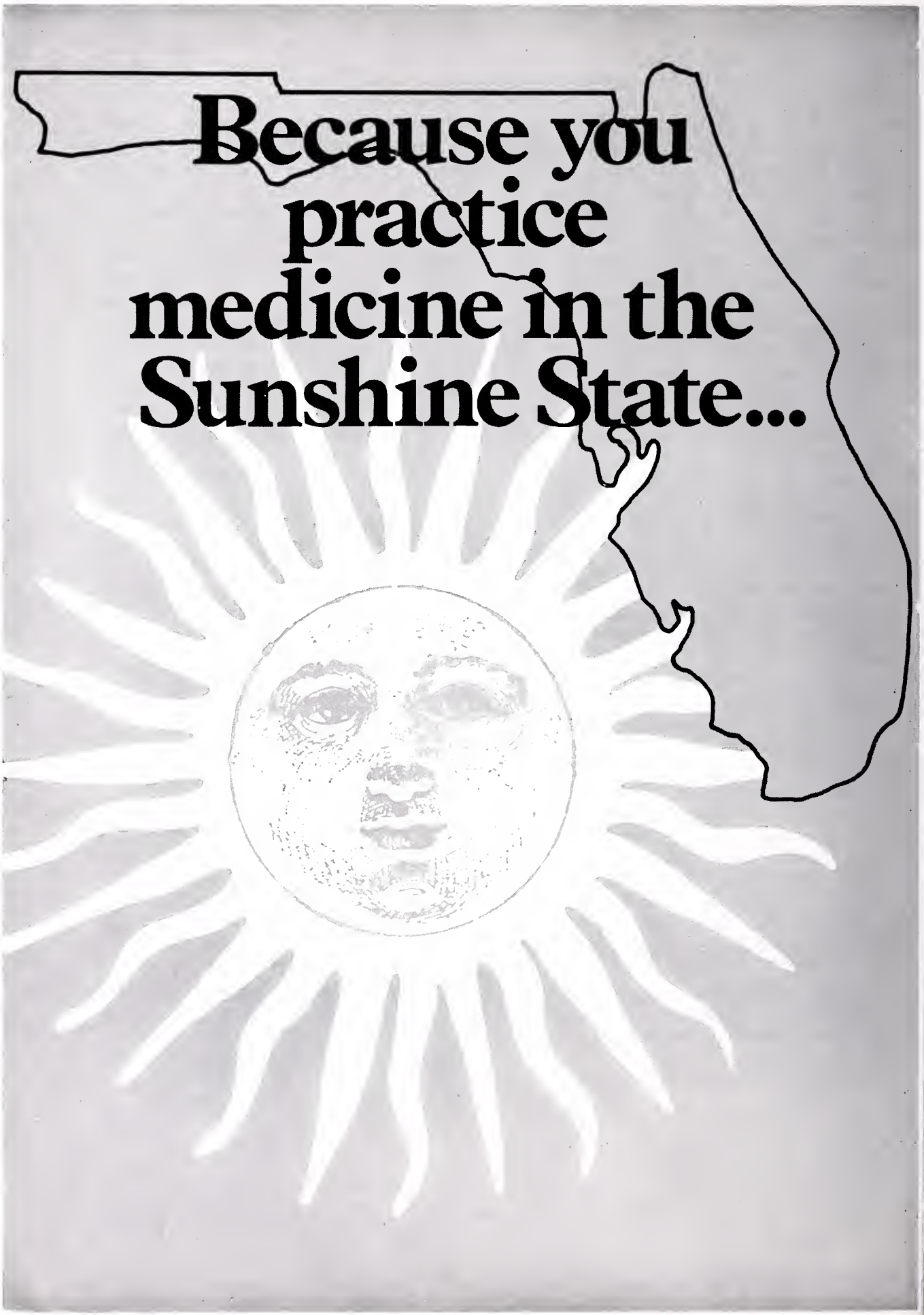
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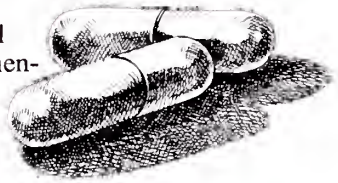

Patient-oriented dosage — up to 8 capsules daily in divided doses

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

To help relieve anxiety-linked symptoms in gastritis and duodenitis

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Before prescribing, please consult complete product information, a summary of which follows:

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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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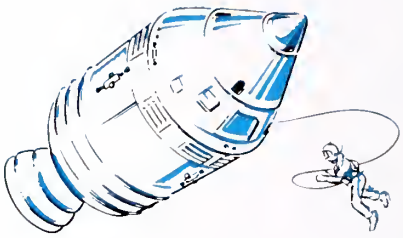

Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

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FMA Layman Award Presented

The Florida Medical Association's first Distinguished Layman Award, voted last year at the annual meeting to former State Sen. Verle Pope of St. Augustine, was presented posthumously to the late lawmaker's daughter in November.

The award, which recognized Sen. Pope's "contribution to the advancement of medical science and medical services in the State of Florida" during his long legislative career, was to have been presented to him during the FMA Annual Meeting last May, however, Sen. Pope's health did not permit him to attend, and he died several weeks later.

Dr. James J. DeVito of St. Augustine (right in picture above), President of the St. Johns County Medical Society presented the award to Sen. Pope's daughter, Mrs. Richard O. Watson at a special dinner. Looking on are Mr. W. Harold Parham of Jacksonville (left), Executive Vice President of FMA, and Mr. Watson.

Conference on Breast Cancer

The American College of Radiology will conduct its 13th annual breast cancer conference, March 4-8 at the Dutch Inn, Lake Buena Vista, near Orlando.

The format will include lectures, panel discussions, short courses, workshops and discussion groups. A registration fee of $75 will be charged.

Information may be obtained by contacting the American College of Radiology, 6900 Wisconsin Avenue, Chevy Chase, Maryland 20015.

Dr. Blank Is Honored

Harvey Blank, M.D., Professor and Chairman of the Department of Dermatology at the University of Miami School of Medicine, has been named a recipient of the Army's Outstanding Civilian Service Medal.

An Army consultant for many years, Dr. Blank and other Miami dermatologists trained Army medics during the Vietnam war to treat skin infections contracted by American soldiers in the swamps of Southeast Asia. They developed a salve to ward off "swamp foot," and produced a field test to identify fungus disease as a prelude to treatment with griseofulvin, an antibiotic which Dr. Blank developed.

What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.

Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

Sequence of therapy— selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

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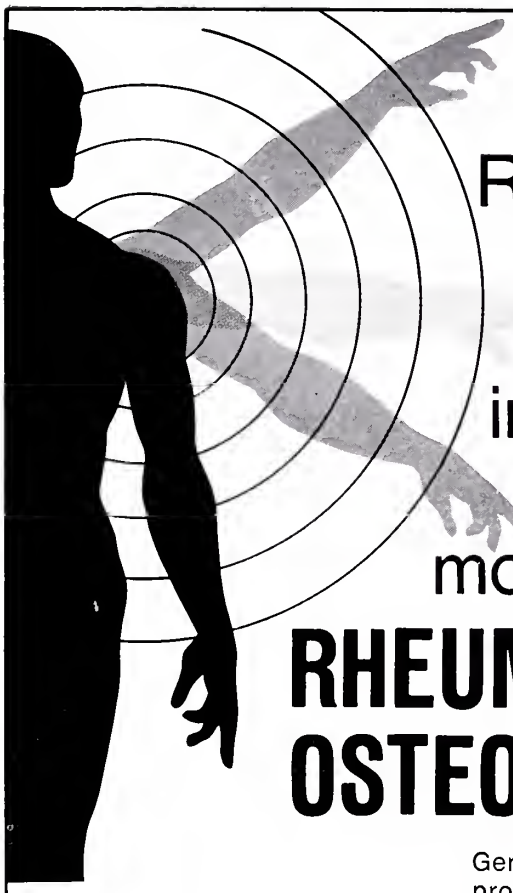

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PRECAUTIONS: Do not use in or near eyes, on open wounds or mucous membranes. Discontinue if excessive irritation of the skin develops.

AVAILABLE: 1½ and 4 oz. cans. Approximately 125 applications in each 4 oz. can.

1. Gordon, E. E. and Haas, A., Indust. Med. & Surg. 28:217, May, 1959.

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Letters

To the Editor: I was shocked to see the article entitled, "A Better Vasectomy" appear in the October issue of the JFMA. The article, at best, lacks scientific substantiation and in one instance is anatomically incorrect. Statements made are unsubstantiated by any facts or figures. There appear to be no controls. I feel compelled to respond to this.

If Doctor Greene crushes, transects and then ties the proximal part of the vas deferens, he will then get what he says he is not getting; that is, vas occlusion. Commonly accepted anatomical nomenclature places the proximal part of the vas toward the testicle and the distal end toward the prostate. Secondly, even if he means to say that the proximal end of the vas is simply crushed, but not ligated, he offers no proof to show whether this crushed end stays open as he presumes it does, or in fact, scars down as most traumatized and most crushed tubular structures will do. To use his own terminology, one might say that the purposeful development of a sperm granuloma is "absolutely unnatural, unphysiologic and undesirable." To go one step further, if the subcutaneous vasostomy is created successfully, sperm is then absorbed in the subcutaneous tissues rather than in the peritubular tissue. The breakdown and actual reabsorption of sperm is thought to be responsible at least for the production of sperm antibodies and so this particular problem is not obviated by the described method.

Whether vasectomy causes the so-called disturbances that Doctor Greene alludes to is speculative, or at best, controversial. Rakha and Igboeli showed no changes in FSH, ICSH or androgen production as measured by seminal fructose after long-term follow-up in vasectomized animals. Bunge has shown no changes in plasma testosterone in man following vasectomy. Other authors have found the same. Kothari and Mishara using a histometric counting method, showed a 25% increase in Leydig cell volume within eight weeks following vasectomy. Howard and James found sperm agglutinating antibodies in 32.6% of their patients studied, but could find no evidence of unusual complications or laboratory evidence of developing autoimmunity, i.e., C-reactive protein, positive STS, rheumatoid factor or antinuclear protein factor in their patients. The reader would best be directed to a recent article in the American Journal of Obstetrics and Gynecology entitled, "Vasectomy—Reviewed," for a scientific, objective, and well-documented review of the subject.

Finally, I am appalled that the editorial staff would allow an article such as this on such a controversial subject to be printed under its auspices. While I realize that printing an article does not imply editorial agreement, one would think that the editorial staff at least had an obligation to insure correctness and documentation of the facts espoused, since any article, once printed, is given stature of a scientific publication.

CHARLES M. LYNNE, M.D.
Assistant Professor, Department of Urology
University of Miami School of Medicine

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3. Howard, P. J. and James, L. P.: Immunological Implications of Vasectomy, J. Urol., 109:76-78, 1973.
4. Kothari, L. K. and Mishara, P.: Vasectomy and Endocrine Function of the Testis, The Lancet, 1:438 (Feb. 19) 1972.
5. Rakha, A. M. and Ighoeli, G.: Pituitary Gonadatropins and Seminal Vesicular Fructose After Long-Term Vasectomy in Bulls, Fertil. & Steril. 22:581-3, 1971.

To the Editor: In reply to Professor Lynne's letter:

1. What can be more unscientific than a diatribe?

2. To avoid any debate on semantics: The cut end of the vas that leads to the testicle is left open and is attached subcutaneously. The cut end of the vas that leads to the prostate is crushed and ligated, and left in place.

3. Facts, figures and controls: How many ways are there to do a vasectomy? (a) cut, and tie the ends; (b) cut out a piece of vas and tie the ends; (c) minor variations of these. In addition, I have also tried securing the testicular end of the vas to the skin behind the scrotum. It didn't work, because the skin insisted on growing over the stoma. I can not visualize, however, a double-

blind study involving one procedure on the right vas and a different one on the left.

4. The only comment that I can make on the lab results—very interesting.

5. At this end in the practice of medicine, patient acceptance and absence of complaints and observable adverse effects become a compelling factor in seeking a better way to do anything.

6. My purpose in writing the article was, of course, to stimulate some thought on the objectives of this procedure; and hopefully, that a better technique will be evolved. I have presented no opinion—only the results of 25 years' experience with this operation.

7. The JFMA is to be commended for publishing articles without editorial censorship. A responsible author, a responsible editor, a free press—cause for shock, horror, dismay? One can always disagree—or disprove.

JOSEPH L. GREENE, M.D.
HIALEAH

To the Editor: I am pleased to outline for you some of the changes that AMA is proposing to make in its scientific programs and in its journal.

As you are probably aware, there has been a declining attendance at large national medical meetings, including those sponsored by the AMA. There is, however, a growing demand by physicians for structured courses and seminars directed to small audiences with recognition or credit being given for attendance. There is also a concern that physicians undergo a formal continuing education process that will make them eligible for membership in some medical societies and in some cases eligible for recertification.

AMA's Council on Scientific Assembly has proposed that the scientific portion of the AMA annual and clinical meeting be separated from the business portion of the meeting and that the scientific sessions be carried to cities where they can be put on cooperatively with either the local, county or the state association. In addition, the Council on Scientific Assembly wants to structure these scientific meetings around formal courses with a printed syllabus and a follow-up self-assessment exam. Since two such courses a year will not permit adequate geographic coverage, the Council is preparing smaller regional meetings in addition to the two annual programs now held. With a course-syllabus structure the programs could be packaged for county societies to use independent of AMA participation.

The Journal of the American Medical Association is the window through which most physicians view the AMA. It should reveal the Association as a scientific organization dedicated to assisting physicians to deliver high quality medical care. It should keep the membership abreast of organizational activities and also interpret medical science in a way that makes clinical science interesting, understandable and practically applicable. To this end the Journal will be restructured to meet the practice needs of physicians delivering day to day medical care. Although medicine is subdivided into many specialties there are enough areas of communality within medicine to support a first class journal.

It is the editor's intention to run regular features on clinical pharmacology, to print case conferences that carry a practical and useful clinical message, to have short, practical tips that will assist in giving good patient care and to keep the profession abreast of new methodology and technology. AMA wants JAMA to be the first journal every physician reads. None of this can be done without the wholehearted support of our membership and we are looking to the leadership in our state and county medical societies to give us that support.

WILLIAM R. BARCLAY, M.D.
ASSISTANT EXECUTIVE VICE PRESIDENT
AMERICAN MEDICAL ASSOCIATION

Open letter to Rep. Forbes

REPRESENTATIVE JOHN R. FORBES
841 EAST BAY STREET
JACKSONVILLE, FLORIDA 32202
Dear Representative Forbes:

On Monday, September 10, 1973, an article by John R. Barry, Journal Political Editor, appeared in the Jacksonville Journal. The title was "State Licensing Boards Will Face Probe."

The gist of the article was that as a result of the failure of some 2,100 applicants in a test given by the Construction Industry Licensing Board and a probe of this by a special legislative committee during the summer all regulatory boards have become suspect and therefore should face a probe and investigation by a special select

House Committee. The article stated that you were named Chairman of this Committee and Representative Frank Carlucci, also of Jacksonville, was named Vice Chairman.

Mr. Barry quotes you as follows: "Obviously there are problems in Florida (with licensing boards) as there are in other states. The boards are serving as a form of buffer to keep out people who want to get into a profession and they act to protect the business from the public." I submit, Mr. Forbes, that this represents a sweeping, serious indictment of all boards and it is unwarranted if based on criticism or actions of one or two boards and it is in fact a prejudgment of all boards not based on facts. This is especially true in view of the wide differences in occupations and professions regulated by the boards in the Department of Professional and Occupational Regulation and the broad spectrum of types of persons and activities involved in these 29 boards. As one professional man to another, I do not think that such a statement was warranted or a fair and factual conclusion. Such a sweeping indictment appearing in the news media cannot but reflect unfavorably upon and be detrimental to all boards.

The Board of Medical Examiners does not act as a "buffer" to keep out people who want to become licensed to practice medicine and surgery in Florida nor do we "act to protect the business from the public." The philosophy of our Board is that we are a consumer protection agency and to this end our role is to determine that only properly educated, qualified and competent M.D.'s are allowed the privilege of licensure either by examination or endorsement. Furthermore, our role is to be sure that a licensed M.D. maintains his competence, ability, integrity and physical, mental and emotional balance so that he continues to practice effectively, efficiently and with safety to his patients. If this status is not adhered to or maintained, then our further role is to remove him/her from practice until competence and abilities are restored or permanently remove him in the interest of the public safety and welfare.

I would like to summarize some facts which would refute the statement that our Board keeps out M.D.'s who wish to be licensed in Florida. In 1963 (10 years ago) 441 M.D.'s were licensed, there were 5,672 M.D.'s registered within the state and the population was 5,633,000. In 1968 (5 years ago) 699 M.D.'s were licensed, there were 6,576 M.D.'s registered within the state and the population was 6,491,000. Beginning in the 1969 session the legislature enacted amendments to the Medical Practice Act and changes relating to licensure requirements of M.D.'s which had a marked impact on the numbers of M.D.'s licensed subsequently. Among these changes were (1) abolition of the Board of Examiners in the Basic Sciences and thereby the requirement of having to have a certificate in Basic Sciences; (2) elimination of the citizenship requirement; (3) licenses by endorsement if the applicant has been certified by the National Board of Medical Examiners (used by medical schools) or the Federation Licensing Examinations (FLEX) used by 47 of the 50 states within eight years of the date of application; (4) qualifications accepted in lieu of the Educational Council for Foreign Medical Graduates Certificate for graduates of foreign medical schools; (5) issuance of temporary certificates to full time medical school faculty; (6) certification of Physician's Assistants to licensed M.D.'s; (7) for foreign medical graduates acceptance of proof of 5 years licensure in another country or state in lieu of 3 years of AMA approved training in U.S.; (8) issuance of temporary certificate to an M.D. to practice on a year to year basis without written examination if the M.D. will practice in an area of medical need. These changes were all supported by the Board of Medical Examiners.

As a result of the above we now have 10,790 M.D.'s registered in Florida as of September 7, 1973 and 18,430 total registered M.D.'s who hold licenses to practice in Florida. There is no buffer or barrier as these results so obviously demonstrate. Since 1969 Florida has ranked among the first 5 of the 50 states in numbers of M.D.'s licensed yearly and the number of licensed M.D.'s within our state has doubled within 10 years. We now have licensure by endorsement with 47 of the other 49 states and we endorse the graduates of all U.S. medical schools (95%) who took and passed the National Boards.

Prior to 1969 Cuban M.D.'s and other foreign medical graduates had to be U.S. citizens in order to qualify for licensure. Since 1969 when the citizenship requirement was removed the number of Cuban and other foreign graduates licensed in Florida has increased enormously. Since Castro took over Cuba approximately 3,000 M.D.'s left that country. Of this number at least 1,500 (50%) of the total have been licensed in Florida. During our last two examinations 50% of the total applicants were foreign medical graduates

and half of this (25% of the total) were Cubans. Of the 204 unlicensed Cuban M.D.'s in the Dade County area in 1972, 103 of these were 70 years old and 101 were over 60. Some of these were successful in obtaining licensure during the past year, leaving a more or less irreducible minimum who cannot pass because of age and not keeping up with progress in medicine. This would refute your statement in the article when you were mentioning Cuban veterinarians namely, "The same thing is true of (Cuban) medical doctors. They won't let them take the test."

As to the role of our Board in disciplining M.D.'s, I am enclosing reports which show our activity in that field. This is not generally known, realized or publicized. The medical profession with 10,000 plus M.D.'s in-state compares favorably in disciplinary activity with the legal profession with 15,000 lawyers.

Thank you for reading this letter and for the opportunity of presenting these facts about the Board of Medical Examiners for your consideration. As a lawyer you might agree that both sides should have due recourse.

VERNON B. ASTLER, M.D., PRESIDENT
FLORIDA STATE BOARD OF MEDICAL EXAMINERS
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CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults — 600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children — 3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.
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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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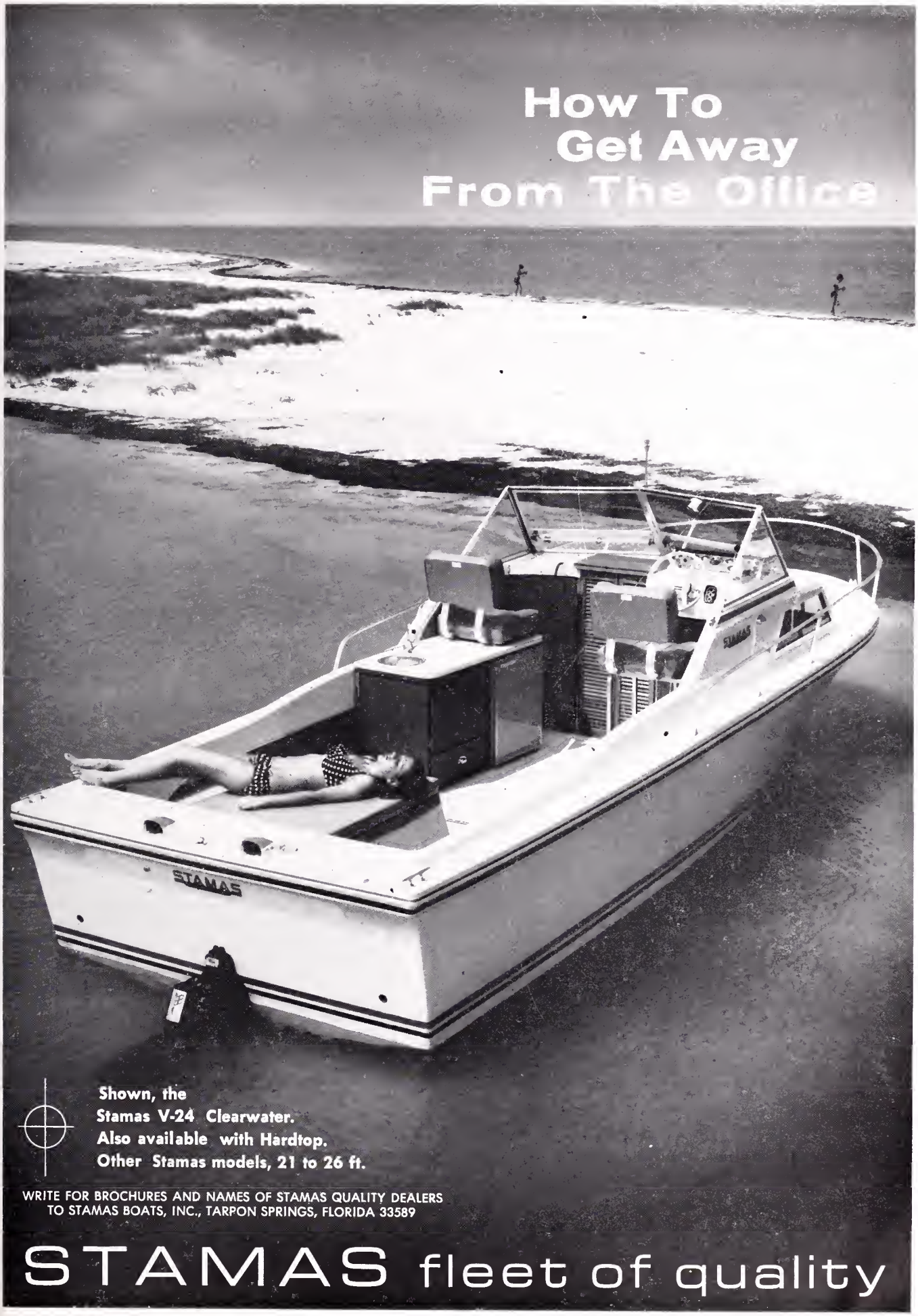
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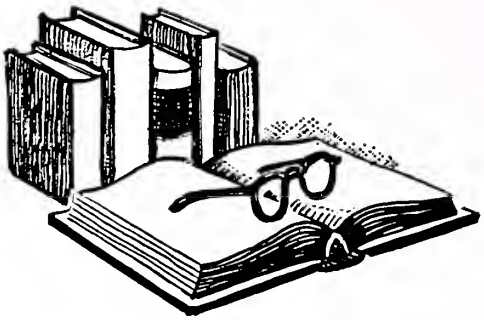

Book Reviews

Richard Asher Talking Sense, edited by F. Avery Jones, 197 pages. Price $2.75. Baltimore, University Park Press, 1972.

Dr. Richard Asher, excellent clinician and engaging medical writer, described and named Munchausen's Syndrome and Myxoedematous Madness. These two descriptions, alone, insure him a small niche in medical history. In the foreword, Lord Rosenheim states, "he was an eccentric in a world that was becoming increasingly uniform; he revelled in the clinical paradox and the unusual; delighted in poking fun at authority and pomposity; a modern Don Quixote.

It was impossible to be dull in the presence of his quick and agile mind. His great interest in his patients, his individualism, his sense of humor will be immediately apparent to all who are now able to enjoy his writing and relive his lectures."

This book is a collection of sixteen of his best lectures and articles including Myxoedematous Madness and Munchausen's Syndrome, gathered together since his death in 1969. Other titles include: "The Seven Sins of Medicine", "Aren't I Lucky? I Can Write!", "Talk, Tact, and Treatment", "The Dangers of Going to Bed", "Malingering", "Diseases Caused by Doctors", and "Talking Sense". His keen wit and clear expression make this collection informative and a delight to read.

His "Talk, Tact, and Treatment" Dr. Asher says, "Another type of patient where some probing may be rewarded is a hypochondriac—a patient who makes a hobby of doctors and drugs . The woman who keeps a diary, not of social functions, but of pelvic functions, the woman who instead of taking up canasta takes up her bowels, and who patronizes the great colonic laundries of Harley Street. If the doctor by his tact can interest her in the world outside instead of the intestines inside, he will have achieved something really worthwhile."

There are rare bargains in books these days. This is one. Buy this for yourself, a colleague, or a medical student. Wives, this would make an excellent gift for your physician-husband.

F. Norman Vickers, M.D.
Pensacola

Games Doctors Play edited by Claude A. Frazier, M.D. 424 pages. 94 illustrations. Price $12.95. Springfield, Ill., Charles C. Thomas, Publisher, 1973.

This book, consisting of 30 chapters, is authored by physicians, and a physician's wife. The sports they cover include table tennis, tennis, volleyball, golf, skiing, swimming, fishing, flying, soaring, ballooning, sailing, and others. There are even chapters on weight reduction and immediate care of athletic injuries. I predict this book would have limited appeal because the serious sportsman would wish to "cone down" on the sport of his choice with reading in depth.

F. Norman Vickers, M.D.
Pensacola

Review of Physiological Chemistry, 14th ed. by Harold A. Harper, Ph.D. 545 pages. Illustrated. Price $8.50. Los Altos, Calif., Lange Medical Publications, 1973.

The intent of the author is to provide those necessary aspects of chemistry which pertain to modern medicine and biology. With this latest edition (14th), 545 pages, essential revisions bring the book as up to date as is practical. Aiding the author are other individuals upon whom he has called for contributions in their particular specialties.

There are twenty two chapters covering the chemistry of proteins, carbohydrates, lipids, body fluids and excretions, body metabolism, and tissues. The appendix has a condensation of essential information on general, organic, and physical chemistry, along with terminology.

The book serves as a handy reference and the bibliography enables the reader to delve deeper into any subject considered. It is recommended for the library of the busy physician.

Perry A. Sperber, M.D.
Daytona Beach

Heritable Disorders of Connective Tissue, 4th Ed. by Victor A. Mckusick, M.D. 878 pages. 1099 Illustrations. Price $32.50. St. Louis, The C. V. Mosby Company, 1972.

Relatively few medical books deserve consideration as "standard reference texts" but the fourth edition of McKusick's Heritable Disorders of Connective Tissue again takes its place as the classic in its field.

Although necessarily larger than the 1966 edition, the plethora of clinical photographs, radiographs, and other illustrative aids continues as a tradition along with an affable literary style so important in technical discourse.

After an introduction to genetics and heredity and a review of connective tissue biochemistry and histology, full chapters are devoted to the classical disorders with separate emphasis given to history, pathology, basic genetic defect(s), and management of each entity. The bibliography in each instance is long and scholarly.

In a field where nomenclature is as fragile and ephemeral as the most recent case study or "International Conference," the author has successfully introduced modern usage, particularly regarding the mucopoly saccharides, now glycosaminogycans.

The text is dedicated to Sir Archibald E. Garrod, successor to Osler as Regius Professor at Oxford and author of Inborn Errors of Metabolism who believed that clinical investigation of hereditary disorders can shed light on normal developmental and biochemical mechanisms. Justice is done to that concept in this book.

Harry W. Eichenbaum, M.D.
St. Petersburg

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Neuro-Ophthalmology, edited by J. Lawton Smith, M.D. and Joel S. Glaser, M.D. 146 pages. Illustrations. Price $22.50. St. Louis, The C. V. Mosby Company, 1973.

The Persecuted Drug—The Story of DMSO by Pat McGrady, Sr. 372 pages. Price $7.95. New York, Doubleday & Company Inc., 1973.

Current Surgical Diagnosis and Treatment edited by J. Englebert Dunphy, M.D., Lawrence W. Way, M.D. 1108 pages. Price $14.00. Los Altos, California, Lange Medical Publications, 1973.

Human Sexuality by AMA Committee on Human Sexuality. 299 Pages. Chicago, American Medical Association, 1972.

Preventing V. D. and Cancer by Circumcision by Abraham Ravich, M.D. 211 Pages. Illustrated. Price $9.95. New York, Philosophical Library, 1973.

Comments in Sports Medicine edited by Timothy T. Craig, Ph.D. 230 Pages. Illustrated. Price $5.00. Chicago, American Medical Association, 1973.

Symposium on Aesthetic Surgery of the Nose, Ears, and Chin edited by Frank W. Masters, M.D. and John R. Lewis Jr., 207 Pages. 514 Illustrations. Price $37.50. St. Louis, The C. V. Mosby Company, 1973.

Mensendieck Your Posture and Your Pains by Ellen B. Lagerwerff and Karen A. Perlroth. 240 Pages. Illustrated. Price $7.95. Garden City, N. Y., Anchor Press/Doubleday, 1973.

Post-Mortem by David M. Spain, M.D. with Janet Kole. 296 Pages. Price $7.95. Garden City, N. Y., Doubleday & Company, Inc., 1974.

What to Do About Your Brain-Injured Child by Glenn Doman. Illustrated by David Melton. 291 Pages. Price $7.95. Garden City, N. Y., Doubleday & Company, Inc., 1974.

Neonatology, Diseases of the Fetus and Infant edited by Richard E. Behrman, M.D. 698 Pages. 215 Illustrations. Price $39.50. St. Louis, The C. V. Mosby Company, 1973.

Hormones by Roger Lewin. Illustrated by Sandra Barnaby. 113 pages. Price $1.95. Garden City, New York, Anchor Press/Doubleday, 1973.

The Neuropathology of the Alimentary Tract by Barbara Smith, M.D. 118 pages. Illustrated. Price $14.50. Baltimore, The Williams & Wilkins Company, 1972.

Parents' Guide to Allergy in Children by Claude A. Frazier, M.D. 338 pages. Illustrated. Price $7.95. Garden City, New York, Doubleday & Company, 1973.

Stress Disease, The Emotional Plague by Peter Blythe. 175 Pages. Price $5.95. New York, St. Martin's Press, 1973.

The Soft Foods Cookbook by Anne S. Chamberlain. 130 Pages. Price $5.95. New York, Doubleday & Company, 1973.

The Cover

Legend for Heart Drawing

1. Anterior descending branch of left coronary artery
2. Circumflex branch of left coronary artery
3. Right coronary artery
5. Aorta
6. Pulmonary artery
7. Innominate artery
8. Left carotid artery
9. Left subclavian artery
10. Right pulmonary artery
11. Left pulmonary artery
14. Superior vena cava
15. Inferior vena cava
17. Great cardiac v.
19. Small cardiac v.
21. R. pulmonary vv.
22. L. pulmonary vv.
26. L. ventricle
27. R. ventricle
29. R. atrium
32. Ligamentum arteriosum
33. Tricuspid valve
34. Mitral valve (bicuspid)
35. Pulmonary valve (semilunar)
36. Aortic valve (semilunar)

This drawing in color of the heart has been prepared as a topographic anatomical study of the normal heart and great blood vessels based upon the medical artist's study of anatomical specimens, radiologic projections, observations during cardiac surgery and consultation with anatomical authorities. Artistic license has been taken, however, in the accentuation of reds and blues to differentiate the blood vessels. The original drawing was prepared by Mr. Leon Schlossberg, Medical Illustrator at the Johns Hopkins University.

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MEETINGS

Approved by FMA Committee on Continuing Education

FEBRUARY

4- 9 Florida Midwinter Seminar in Ophthalmology and Otolaryngology
Americana Hotel, Miami Beach*

4- 9 Courses of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., Box 875, Biscayne Annex, Miami 33152.

17-22 Internal Medicine 1974
Sheraton Four Ambassadors Hotel, Miami*

22-24 Pediatric Dermatology Seminar, Fontainebleau Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

28 Treatment of Serious Infections, Sheraton Four Ambassadors Hotel, Miami*

MARCH

2 Eighteenth Annual Watson Clinic Seminar, Watson Clinic, Lakeland. For information: Gordon F. Moor, M.D., Watson Clinic, Lakeland 33802

7-10 Skin 1974: Modern Management of Common Skin Disorders—Seminars for the Family Physician
Playboy Plaza Hotel, Miami Beach*

8- 9 Allergic Diseases, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

13-15 Fifth Annual Topics in Internal Medicine
Hilton Hotel, Gainesville**

13-16 Sixth Teaching Conference in Clinical Cardiology
Sheraton Four Ambassadors Hotel, Miami*

13-17 Thyroid and Endocrine System Investigations With Radionuclides, Playboy Plaza Hotel, Miami Beach*

14-15 Electrodiagnosis and Management of Back, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

15-18 The Phono and the Physical, Hilton Hotel, St. Petersburg. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

18-23 Instruction Courses in Coronary Care for the Practicing Physician, University of Miami School of Medicine, Miami*

26-30 Radiology in Medical and Surgical Emergencies. Playboy Plaza Hotel, Miami Beach*

29-30 Genetic Resultant Conditions, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

APRIL

3- 5 "Clinical Nephrology and Heart Disease II," Eden Roc Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

8- 9 Hypertension, Sheraton Four Ambassadors Hotel, Miami*

8-12 Ophthalmic Plastic and Corneal Surgery
Doral Hotel, Miami Beach*

18-22 Thirteenth Workshop in Electrocardiography for Physicians and Cardiac Nurses, Tides Hotel and Bath Club, Redington Beach. For information: Henry J. L. Marriott, M.D. St. Anthony's Hospital, St. Petersburg 33705

19-20 Practical Optics and Refraction, J. H. Miller Health Center, Gainesville**

22-27 Courses of Instruction in Coronary Care for the Practicing Physician, University of Miami School of Medicine, Miami 33152*

25-27 Urology: Selected Topics for the Practitioner, Hilton Hotel, Gainesville**

MAY

2- 4 Master Approach to Cardiac Emergencies
Contemporary Hotel, Disney World, Orlando*

3- 4 The Management of the Critically Ill Patient, Hilton Hotel, Gainesville**

4 Intensive Care Symposium (Department of Surgery, University of Miami, in cooperation with the Department of Anesthesiology, University of Florida College of Medicine)
University of Florida, Gainesville*

9-11 Clinical Care of Bone Tumors, University of Florida, Gainesville**

9-12 Microneurosurgery, Innisbrook Resort & Gulf Club, Tarpon Springs**

13-18 Instruction Courses in Coronary Care for the Practicing Physician, University of Miami School of Medicine, Miami*

17-18 Acute Coronary Care, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

24-26 Instrumentation in Cardiology, Port O'Call Resort, St. Petersburg. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

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*For Information: Contact the Division of Continuing Education, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32601.

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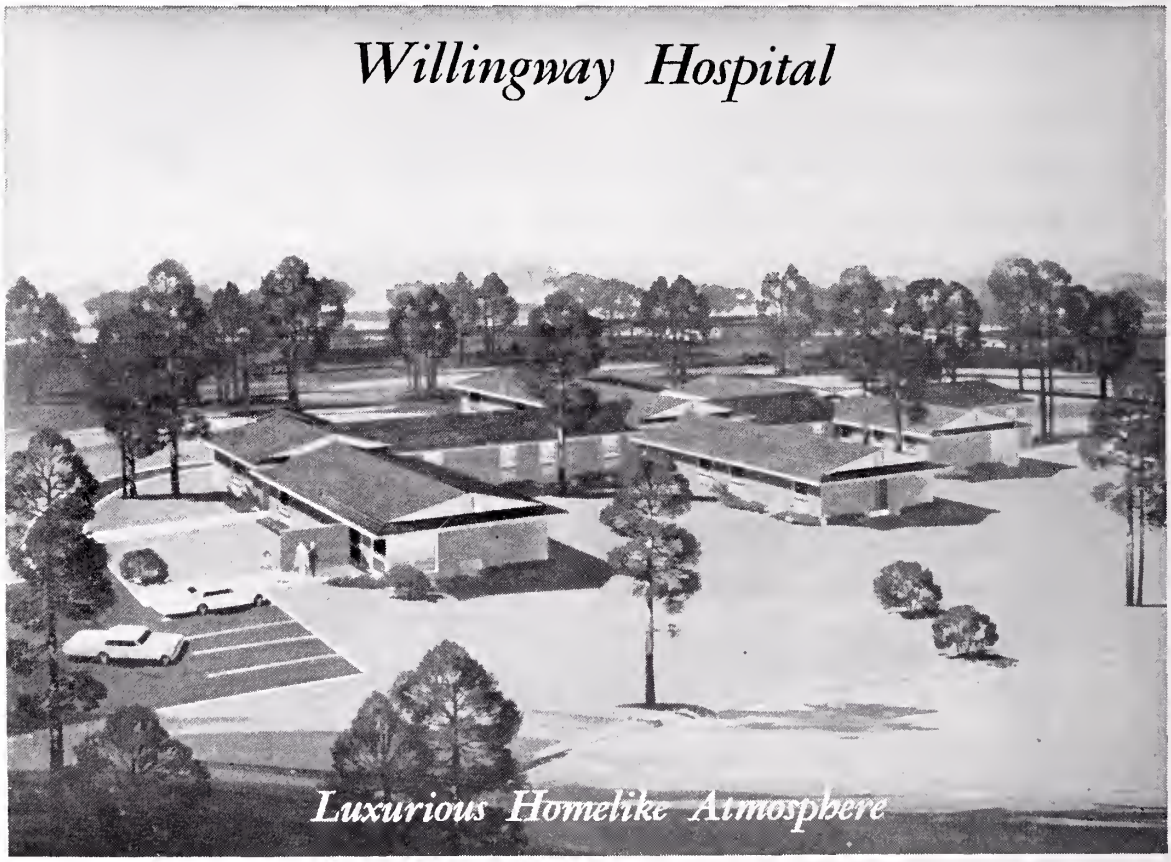

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It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased by Increments of	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	monthly 1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	monthly 0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac Patients	0.5-1.0 mg.	monthly 1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
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Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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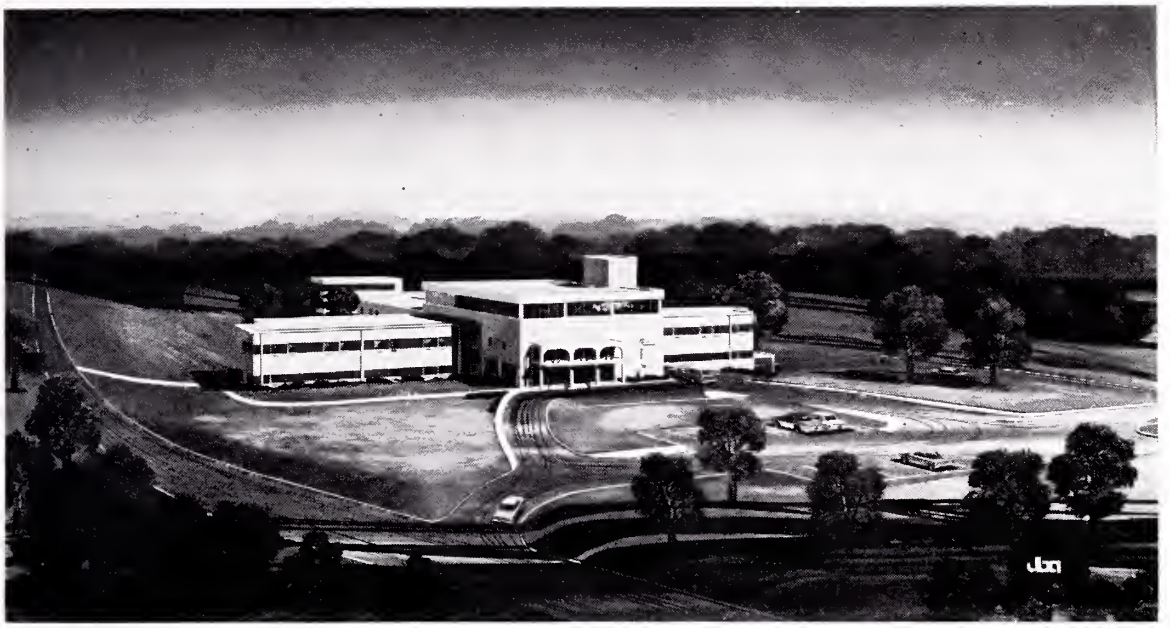

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UROLOGIST, 30, married. Board eligible, university trained. Seeking association, partnership or group affiliation. Available June 30, 1974. Harris D. Slavick, M.D., 15 Merion Lane, Willingboro, New Jersey 08046. (609) 871-9619.

INTERNIST: Board certified, Florida license, in military service, available part time for internal medicine consultations, ECG interpretation. Central Florida area, will travel. Write C-618, P.O. Box 2411, Jacksonville, Florida 32203.

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OF THE FLORIDA MEDICAL ASSOCIATION, INC. • MARCH 1974

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MARCH COVER — "Sunrise Fishing on the Withlacoochee River," a prize winner in the 1971 Saturday Review contest, by Thomas D. Dorr, M.D., Tampa, Florida, used with permission of Mrs. Dorr and Saturday Review, January 1, 1972. Copyright 1971 Saturday Review, Inc. Dr. Dorr passed away September 29, 1973.

President's Page

January 27 - 3 PM - Orlando

Leadership Conference

The door to the presidential suite had closed—it was now Sunday afternoon—the speakers finished—the county leaders gone. No more jokes—no more eulogies—no more philosophy—Harold had said "Goodbye for now." I sat alone reflecting.

Jim Walker, Dick Dever, Bob Windom, Byron Thames, Franklin Evans and Irving Hall had done an excellent job of discussing the Florida Medical Association for the benefit of those in attendance.

Sanford Mullen, George Evans, Lou Murray, Ed Annis, Burns Dobbins, and Jack MaCris had portrayed the excitement of legislation and political action in such a way that others will inevitably become involved.

Vern Astler had articulated his fears. Emanuel Papper had described medical education. Jerry Schiebler had captivated us all.

A warm glow had permeated the room, and an understanding of the true significance had evolved when Bill (Hog?) Roberts and Jim Cook nostalgisized. They had become the sine qua non of what it is all about.

It is not my intention to eulogize these men; but if that be the result, they are deserving.

I was weary, yet pleased, as the highlights of the conference still occupied my mind. It occurred to me, however, that these were dedicated physicians who had devoted two days to telling their stories, and they were also tired. They had not been rewarded monetarily, but most have exacted a degree of satisfaction from the knowledge that their efforts had contributed to the preservation and improvement of medical practice.

To me, the value of this experience is elevated by the voluntary nature of participation in a county society which can neither grant nor remove the right to practice medicine. Those who contribute to and support the work of its societies, therefore, do so with unselfish motives and the sacrifice of time and other resources. I count my blessings once again as I realize that a leadership program like this could have taken place in no other country of the world.

Most editorials and news releases written today focus on a man's misdeeds; but, now it was time to discuss leadership and accomplishments with pride. You see, I believe in these men, and I want all *9,020* members of the FMA to know

- about my weekend
- about the leadership system in action
- about this exemplary group of physicians
- about the 100 years of the FMA
- about the noble legacy we have inherited
- about Harold Parham's excellence
- about how fortunate we are to have physicians representing us all, and,
- about their efforts to promote the science and art of medicine and the betterment of the public health of the people

Maybe a simple thank you is inadequate, but, the resulting product must speak for itself; a physicians' organization, existing to serve you and your patients.

acute gonorrhea

This patient
just received
an effective, private,
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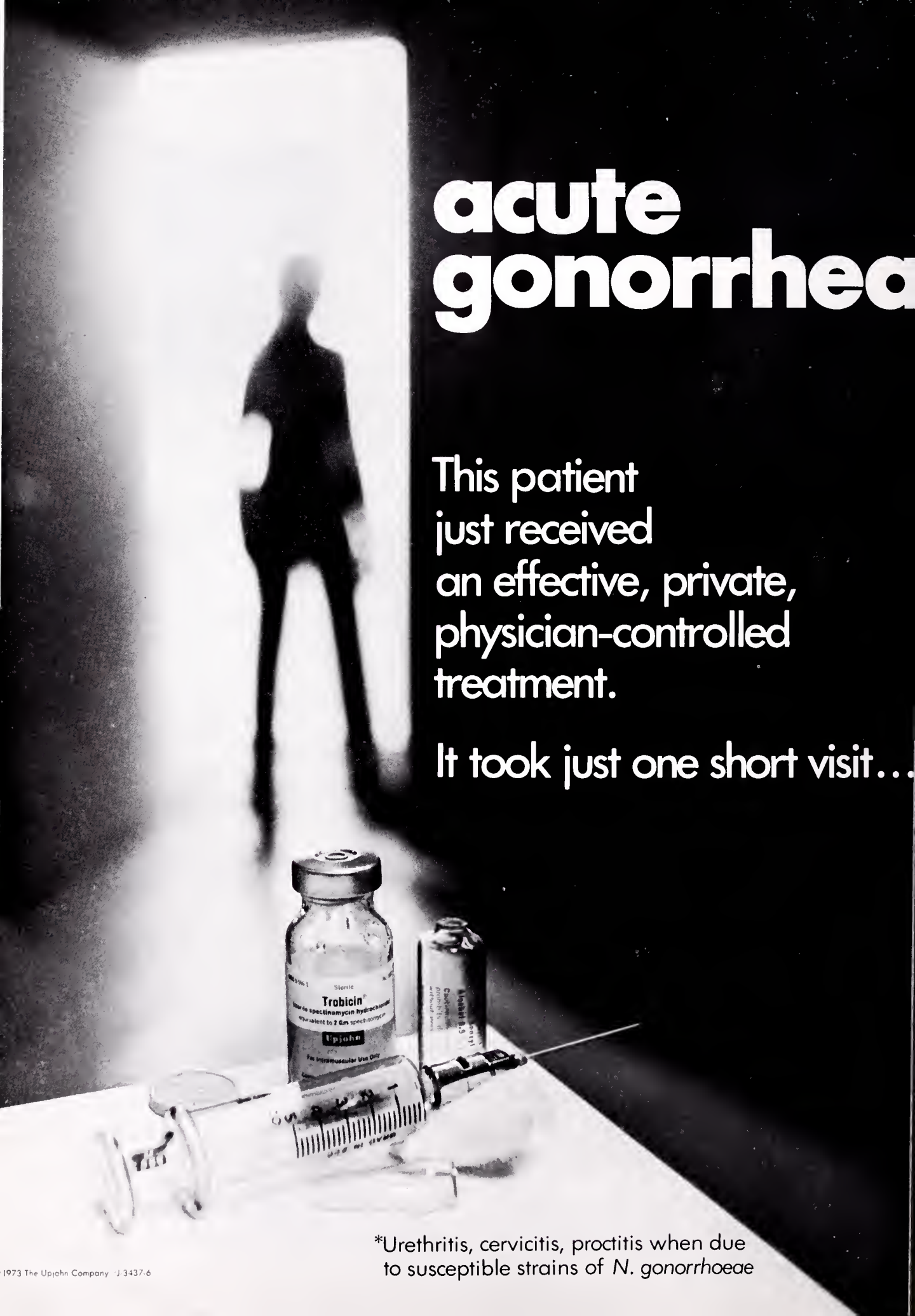
treatment.

It took just one short visit...



*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Medical News

16th FMA Leadership Conference

The Florida Medical Association's 16th Annual Leadership Conference for county medical society officers attracted 176 persons, including 130 physicians, to the Kahler Plaza Inn in Orlando on Saturday, January 26. Thirty-four of FMA's 43 county medical societies were represented.

The conference featured more speakers but briefer presentations than in past years. Guest speakers included the Hon. O. J. Keller, Secretary of Florida's Department of Health and Rehabilitative Services, and Edward R. Annis, M.D., Past President of the American Medical Association. Members of the FMA Board of Governors and Council Chairmen discussed their programs and activities.

Secretary Keller said he welcomed the advice of the FMA on health matters within his large agency and outlined some of the health-related problems confronting the Department and its component divisions.

Reporting on "The National Medical Scene" after a buffet luncheon, Dr. Annis related that "what I have seen in Washington is not grounds for optimism." He said the climate is ripe for the passage of some type of national health insurance in the next year or two.

Joseph C. Von Thron, M.D., Cocoa Beach, President of the Florida Medical Association, presided at the morning session, while Thad Moseley, M.D., Jacksonville, President-Elect, did the honors in the afternoon. At his questioning of the physicians present, a show of hands revealed slightly more than half had been members of the FMA less than 15 years.

The all-day conference was followed on Sunday morning by a panel on state and national legislation of interest to medicine. Guest speakers included Congressman Lou Frey of Orlando; State Sen. Louis de la Parte of Tampa and State Rep. Don Tucker of Tallahassee.

Dr. Nagel Leaves Miami

Eugene L. Nagel, M.D., Professor of Anesthesiology at the University of Miami School of Medicine and Assistant Editor of *The Journal,* resigned effective March 1 and has moved to California.

Dr. Nagel will be Chairman of the Department of Anesthesiology at Harbor General Hospital, Torrence, Calif., and Professor of Anesthesiology at ULCA.

One of the founders of Miami's Emergency Rescue Service, Dr. Nagel also will be working with the Los Angeles area's large system.

The Journal staff, reluctant to say goodbye to one of its luminaries, wishes him much success in all of his future endeavors.

Prep Course for Foreign Graduates

The University of Miami School of Medicine has agreed to participate in a pilot program designed to prepare foreign medical graduates for licensure examinations.

The nine-month refresher course begins April 1, 1974. It was developed by the National Health Service Corps and the Commission on Foreign Medical Graduates.

Under the program, the University of Miami, through its Office of International Medical Education, will admit up to 150 foreign graduates who wish to practice in areas of the United States where physicians are in short supply.

Laboratory Examinations Scheduled

The Florida Division of Health has announced that the next clinical laboratory licensure examinations will be given May 14 and 15 at several locations in Florida.

Applicants for the examination should file their applications by March 22 with the Bureau of Laboratories, Florida Division of Health, P. O. Box 210, Jacksonville.

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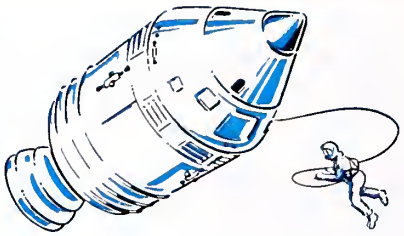

Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

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Dean's Page

Quality of Excellence

Chandler A. Stetson, M.D.

For the last fifty years, American medical schools have operated upon the premise that medical education programs must be of excellent quality if the profession of medicine is to be all that it should be, and if the American people are to have the best possible health care. It is to ensure the quality of excellence that our admissions committees have invested so much time and effort in trying to identify the best-qualified students, that we have emphasized the training and recruitment of able scientist-teachers and physician-teachers to our facilities and that such heavy investments have been made in the teaching facilities on our medical school campuses. The objective of all of this has been to provide highly qualified students with high-quality medical education, based on our conviction that the very nature of the profession of medicine leaves no room for mediocrity or inferiority and that our patients deserve nothing less than the very best that our system can provide, including the very best in medical education.

Recently, there have arisen some serious threats to that basic premise. In response to public and governmental concern over the "doctor shortage," most of our medical schools have undertaken massive expansion programs. This year, for example, over 14,000 students are enrolled in first-year medical school classes as compared to around 8,000 a decade ago. There has been a comparable expansion in the numbers of interns and residents, nursing students, dental students, pharmacy students and allied health professional students. Incentives have been offered to expand class sizes, shorten the curriculum, etc., but there are several indications that this concentration on sheer growth in numbers is resulting in erosion of quality in our teaching programs. In both public and private schools, funds from both governmental and private sources have not been adequate to keep up with the expansion of student class size. As a consequence not enough new faculty members can be hired, and the present faculties are consequently becoming older, overworked and a bit less likely to stay abreast of new developments in medicine. More and more across the nation, clinical faculty time is being too heavily invested in private practice fee generation, in an effort to help meet the medical schools' bills, rather than in teaching and in generation of new knowledge. Finally, federal cutbacks in support to medical schools have been severe, resulting in what amounts to austerity programs which have the flavor of holding actions rather than of vigorous improvement, growth and renewal. I don't mean to overstate the case and to suggest that we have an emergency or crisis situation. I *do* mean to say that there is clear evidence that we are caught in a slow drift away from the emphasis on quality and excellence that has pervaded the American medical school scene since the Flexner report sixty years ago. We must be scrupulously certain that efforts to make medical education (and medical care!) less costly do not result in sacrifice of quality.

We badly need a firm and stable national policy on medical education, on such matters as the numbers of students we should be educating. Opinions in Washington have blown hot and cold over whether or not there is a "doctor shortage." After several years of pressing our medical schools to expand, suddenly this year the official line in HEW is that we are training enough and maybe more than enough physicians by the early or mid 1980's. And yet, mirabile dictu, the Veterans Administration is right now offering "assistance grants" to affiliated medical schools if the medical schools will only agree to further expand their class sizes!

Those of us with responsibility for planning and management of our medical schools find it difficult to cope with federal policies that are here today and gone tomorrow. Too often our medical schools have been left holding the bag, with a commitment and investment in programs in which Washington suddenly decides it has no further interest. Our chief concern, in the last analysis, is for the quality of our educational programs which form the basis on which the standards of our profession rest.

▶ Dr. Stetson, University of Florida College of Medicine, Gainesville 32601.

Dr. Stetson is Dean, University of Florida College of Medicine, Gainesville.

FMA Centennial Annual Meeting, 1974

The 1974 (Centennial) Annual Meeting of the FMA will be held at the Diplomat Hotel in Hollywood, Florida, May 8-12. Friday, May 10, has been set aside for a special celebration commemorating the 100 years that FMA has served the physicians and the citizens of Florida. A very special program is in the making on Friday—one that will:

Bring a Smile
Make Your Spine Tingle
Warm the Heart
Moisten the Eyes
Strengthen the Conscience
Pay Tribute to an Honorable Profession and
many of its Honorable Men.

Plan now to attend the 1974 Annual Meeting and participate in the Centennial Celebration—after all *You Are The FMA* and it's *Your Birthday*.

SEE PROGRAM HIGHLIGHTS, PAGE 245.

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Sunday, MARCH 31 (7:30 p.m. EST), "The Wonderful World of Disney" is proud to present *The Magic of WALT DISNEY WORLD.* Many of you are planning to visit the Vacation Kingdom in the future . . . this program will answer many questions on what to do, where to go, and how to see WALT DISNEY WORLD. Families nationwide will experience the entertainment wonders, thrills, and excitement of a visit to the Magic Kingdom, via their own television set!

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Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inositol	10 mg
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg.
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.
Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

ACTION AND USES—*DOSAGE:* 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. *PRECAUTIONS:* Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. *CONTRAINDICATIONS:* Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. *AVAILABLE:* Bottles of 30, 100, and 500 tablets.
TESTAND-B INJECTABLE: VIALS OF 10cc.

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Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
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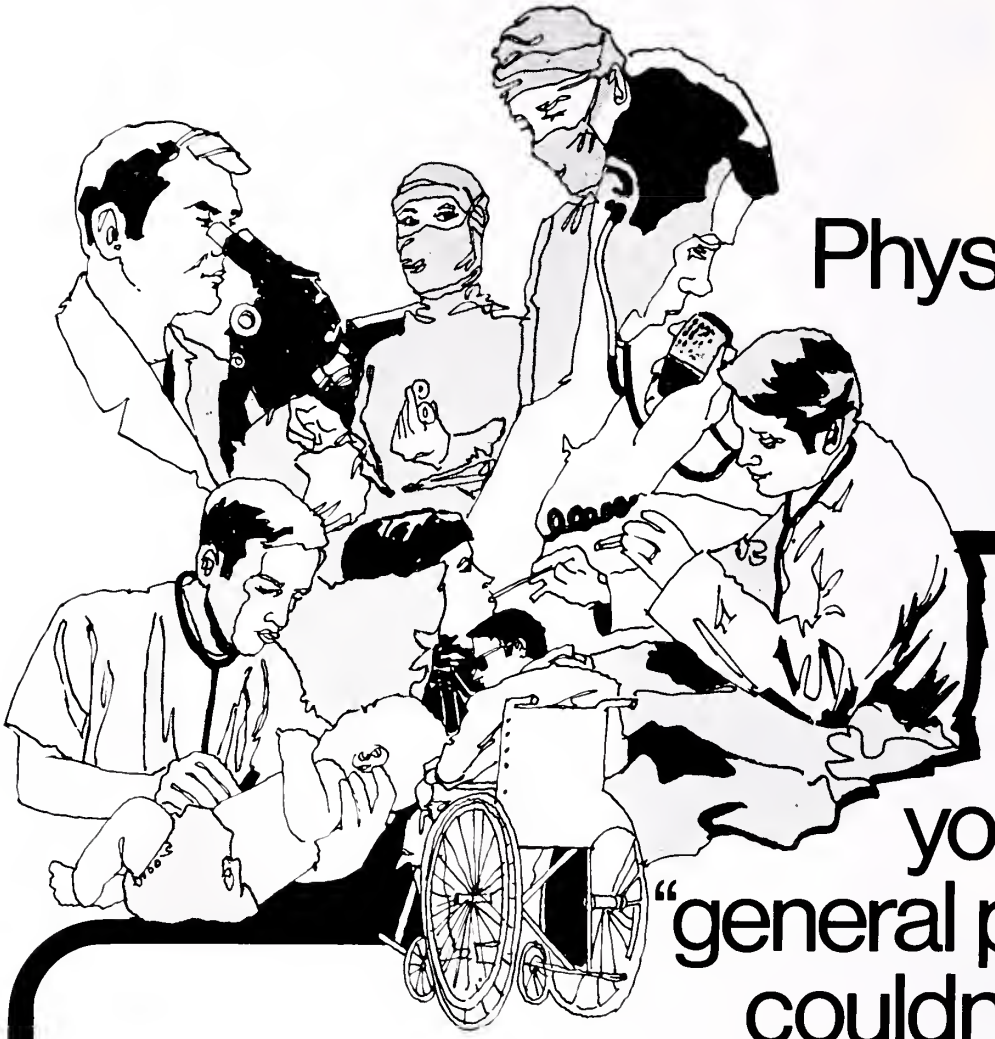

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Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Neuro-Ophthalmology, edited by J. Lawton Smith, M.D. and Joel S. Glaser, M.D. 146 pages. Illustrations. Price $22.50. St. Louis, The C. V. Mosby Company, 1973.

Current Medical Diagnosis and Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1,018 pages. Price $12.00. Los Altos, California, Lange Medical Publications, 1974.

Human Sexuality by AMA Committee on Human Sexuality. 299 Pages. Chicago, American Medical Association, 1972.

Preventing V. D. and Cancer by Circumcision by Abraham Ravich, M.D. 211 Pages. Illustrated. Price $9.95. New York, Philosophical Library, 1973.

Comments in Sports Medicine edited by Timothy T. Craig, Ph.D. 230 Pages. Illustrated. Price $5.00. Chicago, American Medical Association, 1973.

Symposium on Aesthetic Surgery of the Nose, Ears, and Chin edited by Frank W. Masters, M.D. and John R. Lewis Jr., 207 Pages. 514 Illustrations. Price $37.50. St. Louis, The C. V. Mosby Company, 1973.

What to Do About Your Brain-Injured Child by Glenn Doman. Illustrated by David Melton. 291 Pages. Price $7.95. Garden City, N. Y., Doubleday & Company, Inc., 1974.

Hormones by Roger Lewin. Illustrated by Sandra Barnaby. 113 pages. Price $1.95. Garden City, New York, Anchor Press/Doubleday, 1973.

The Neuropathology of the Alimentary Tract by Barbara Smith, M.D. 118 pages. Illustrated. Price $14.50. Baltimore, The Williams & Wilkins Company, 1972.

Parents' Guide to Allergy in Children by Claude A. Frazier, M.D. 338 pages. Illustrated. Price $7.95. Garden City, New York, Doubleday & Company, 1973.

Clinical Research for All by Cyril Maxwell, M.B., Ch.B. 165 Pages. Illustrated. Price $8.00. Northampton, England, Cambridge Medical Publications Limited, 1973.

Practical Spanish for Medical and Hospital Personnel by Marguerite D. Bomse and Julian H. Alfaro. 176 Pages. Illustrated. Price $4.50. New York, Pergamon Press, Inc., 1973.

Hyperbaric Oxygenation—The Uncertain Miracle by Vance H. Trimble. 236 Pages. Illustrated. Price $6.95. Garden City, N. Y., Doubleday & Company, Inc., 1974.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies are known to occur
USUAL DOSAGE: Adults – 600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule. 900 mg initially, followed by 300 mg q i.d for a total of 5 4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia 900 mg daily for six days.
Children – 3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
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- The American Academy of Dermatology
- The Board of Directors of the American Academy of Family Physicians
- The Executive Board of the American Academy of Neurology
- The Committee on Drugs of the American Academy of Pediatrics
- The American College of Allergists
- The Executive Committee of the American College of Obstetricians and Gynecologists
- The Board of Regents of the American College of Physicians
- The Board of Trustees of the American Dental Association
- The Board of Trustees of the American Medical Association
- The American Psychiatric Association
- The Executive Committee of the National Association of Retail Druggists
- The Board of Directors of the Pharmaceutical Manufacturers Association
- The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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The Office Management of Chronic Bronchial Asthma in the Adult

NELSON ZIVITZ, M.D.

Abstract: The clinical course of the chronic asthmatic is quite unpredictable. Strangely, the occurrence of some other acute disease process is often associated with a remission of asthma. Perhaps endogenous adrenal hormone from stress, nonspecific protein reactions, or psychogenic transfer reaction explain this phenomenon. Care should be taken to avoid attributing such a remission to the current treatment, but this remission provides a good opportunity to intensify all investigative procedures. For example, a psychiatrically oriented interview is possible only when the patient is free of acute respiratory difficulty. Diet trials, provocative testing and skin testing will be far more significant in the absence of drugs that diminish the activity of the antigen-antibody union. All this also is an integral part of the office management of chronic bronchial asthma.

The patient with classical chronic bronchial asthma presents a persistent or frequently recurring syndrome of wheezing, cough and dyspnea. Wheezing, which predominates, and dyspnea respond to the usual medications directly and proportional to the severity of the syndrome. Cough, when productive, yields a glary white mucous varying in thickness and viscosity and containing spirals, crystals and eosinophiles. There is usually a familial history of allergy and the past history may include atopic eczema, seasonal rhinitis and asthma, and less often urticaria and migraine. The developmental history indicates that onset can occur at any age and that the seasonal incidence gradually lengthens so that symptoms become perennial and persistent, often with winter exacerbations. Since environmental and atmospheric allergens are the etiological agents in this uncomplicated form of asthma it is referred to as "extrinsic asthma." The single antibody system involved is the combination of a specific environmental or atmospheric antigen with specific antibody attached to bronchial mast cells resulting in degranulation of the mast cell and release of chemical mediators such as histamine, serotonin, acetylcholine, slow reacting substance and bradykinin. There is evidence that serum IgE values are increased where extrinsic factors predominate. In certain parts of the country climato-therapy is often initially successful followed by a return of symptoms, most commonly after two years. Signs and symptoms are very minimal during rare periods of remission but latent bronchospasm can usually be demonstrated by forced expiration and simple pulmonary function studies.

Unfortunately, the patient does not always present a classical picture and the differential diagnosis can be very complicated[1] and resolved only by physical findings, sputa studies, chest x-ray in inspiration and expiration, electrocardiogram, hematocrit, ventilatory studies, lung volume and diffusion studies, and arterial blood gases. A common disease requiring differentiation is chronic

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bronchitis with bronchospasm which can occur at any age but usually presents in the third and fourth decades with the basic history of repeated colds, grippe, flu, sinusitis and bronchitis, usually in the winter months and always nonseasonally. It is commonly referred to as "intrinsic asthma" since external allergens are not demonstrated. It is believed that both IgE and IgG antibody complexes can be involved in what, at present, is an unclear mechanism. As investigative techniques improve many of these patients may be found to have primarily extrinsic disease. This type of asthma, in my experience with both children and adults, is more likely to progress to intractable asthma in which the etiology is so complex as to suggest an autoimmune phenomena. In any event, cough becomes gradually more troublesome, of longer duration, less responsive to medications, more productive of purulent secretions and with less complete remissions. The cough usually predominates but wheezing and dyspnea occur in varying degree until all symptoms are more or less persistent and he is cryptically called the "Blue Bloater" due to cyanosis.

Some patients, often older and in the fifth decade of life, give the history of a slowly progressive problem of indefinite onset characterized primarily by dyspnea and fatigue, with negligible cough, little mucoid sputum containing mostly epithelial cells and polys, questionable wheezing on exertion, an almost total lack of remission, with a tendency to become progressively worse with a poor response to therapy. A descriptive term for this patient is "Pink Puffer" since he is hyperaerated from chronic pulmonary emphysema. These diseases and others such as chronic lung diseases, bronchiectasis, bronchial obstructive lesions, right heart failure, or pulmonale, and a host of pulmonary hypersensitivity reactions such as extrinsic allergic alveolitis may exist independently or as complications of chronic bronchial asthma.

Office Management Plan

After consideration of the history with physical findings and laboratory results leading to the diagnosis of chronic bronchial asthma, a rational plan of office management can be adopted:

1. The chronic asthmatic may well have other medical problems that are unrelated to the respiratory system. The welfare of the patient and the status of the physician are always enhanced by the discovery and treatment of concomitant disease.

2. The allergenic factor whether a specific antigen or a nonspecific osmyl, when discovered and properly managed, offers the patient the most definitive benefit. These factors are discovered by history, observation, environmental control, skin tests, provocative testing elimination diets, and therapeutic trial. The art of history taking is learned in medical school but perfected only by practice and greater knowledge of the disease. Observation by the patient, as well as the physician, is important and four questions constantly emerge when discussing the period before the onset of an exacerbation of chronic asthma: What did you do? Where did you go? What did you eat? How did you feel emotionally? Environmental control and therapeutic trial accomplished by the manipulation of exposure to a woolen blanket, animal danders, smoke, specific suspected foods, and places of work or sleep can be most informative. Skin testing with fresh and sterile extracts is an art in which the physician must differentiate nonspecific, irritating, and irrelevant responses. Serial dilutions can be most helpful. Indeed, the big advantage held by the allergist is that his extracts are used up so fast that they are always fresh and contamination is easily recognized. Probably scratch test materials are most safe for general usage. Provocative testing in my office has been limited to conjunctival and intranasal techniques for inhalants. Clinically recognized foods and inhalants giving positive skin tests are eliminated. Questionable foods are eliminated from the diet for at least two weeks and ingested one at a time for three mornings in a row at home on awakening and unmixed with other foods for at least one hour. I have had no experience with subcutaneous or intracutaneous injection of food extracts in serial dilutions until symptoms of allergy occur. Of great interest is that these clinical manifestations can be aborted by either a smaller or larger dose (depending on the patient) of the same antigen administered in the same manner as the provocative dose. As one would expect, other studies using double blind and cross-over techniques question these results. Finally, bronchial challenge by inhalation of the antigen is very diagnostic for inhalant allergy but should be performed only in a hospital setting with constant medical supervision.

No other form of treatment can be as effective as the avoidance of the causative factor. Hyposensitization is always a compromise but in many situations the only alternative. However, the allergy survey has been greatly complicated by

the complexities of modern living with exposure to such things as coloring agents, preservatives, plastics, mites, the demonstration of antilung antibodies, serological evidence of mycoplasma infections, laboratory proof of sensitivity to the breakdown products of food, multiplicity of prescribed drugs and their interactions. Today's enlightened patient has almost, but not quite, eliminated the common allergens of the past such as a cat or feather pillow.

The question of bacterial allergy and the use of respiratory vaccines (stock and autogenous) in the etiology and management of asthma has been debated for a long time and has recently come under attack by the Federal Drug Administration. It has been very difficult to provide immunologic proof but long clinical experience cannot be discarded. After all, the "body" of bacteria is protein. Immediate (wheal, flare, itch) and delayed (arthus-type) skin reactions are seen frequently. Overdose (focal) reactions are dose related, manifested by asthma, and occur often enough to make one ever alert to their occurrence. And finally, the clinical benefit is readily apparent in many of my patients and usually directly related to the dose administered.

3. There are ancillary benefits from the allergic approach. A positive skin test is very dramatic and reassuring to the discouraged patient. The regular visits enables one to adjust medications, recognize early onset of respiratory infection, discuss environmental changes, encourage the patient to maintain a prescribed restricted diet while avoiding loss of necessary food substances and iatrogenic diet problems, discuss current emotional stress, recognize the development of associated and complicating diseases; all while utilizing the injection technique to approximate the value of "laying on the hands" so successfully used by other professional groups.

4. Environmental control should be thorough. Allergens should be eliminated whenever possible on the basis of the patient's observations, positive skin tests, and those allergens and irritants commonly known to induce and aggravate the asthmatic syndrome (camphor, insecticides, etc.). However, the extent of this avoidance program usually depends upon whether the allergist adopts a passive or aggressive authoritative role. Individualization is required based upon the patient's lifestyle and his reaction to recommendations. I find that an after dinner smoke can be accepted until an adverse effect is demonstrated and a recalcitrant patient is converted into an ally. At times there are situations when a cat or dog can or must be accepted in the house but not in the bedroom. Furthermore, the technique of hyposensitization can be temporarily utilized with the acknowledgement that it is never as effective as avoidance. Medical supply companies have made possible the opportunity for the patient to observe possible benefits from dehumidifiers and humidifiers simply by renting a unit for a month and, if effective, applying this rental fee toward the purchase price. The patient's attention must be directed to the need for keeping these units clean to avoid other problems (hypersensitivity alveolitis-aspergillosis, for example). Air-conditioning which permits the windows to be kept closed and electrostatic air filters are of proven value in selected cases. The simple expedient of having the patient open the bathroom door while drying after a bath or shower minimizes the adverse effects of temperature change when emerging from the room. A thermos bottle with hot tea or coffee at the bedside can be available to the patient on awakening and often deters symptoms from chilling. Avoidance of rush hour driving can eliminate stress and much air pollution. Attention to accumulated dust inside his automobile can be very rewarding. A cooperative patient can be of great help during the survey by his recognition and management of such details.

5. Symptomatic drug therapy is directed against the basic pathology of edema of the bronchial mucosa, smooth muscle spasm, hypersecretion of mucous glands and thickening with inspissation of mucoid material in smaller bronchi. Fortunately, there are effective drugs available in many combinations and a general routine with individualized variations can be developed.[2] The xanthines are effective bronochodilators, tend to increase cardiac output and increase vital capacity. These effects are best obtained by intravenous injection, somewhat less by rectal instillation, and minimally but effectively, orally. Choledyl 200 mg t.i.d. is effective but, since the liquifactive effects of glyceryl guaiacolate are usually desired, Quibron, Brondecon or Lufyllin-GG can be prescribed. There are other combinations containing ephedrine. In addition to gastrointestinal intolerance the xanthines have a mild diuretic and, therefore, dehydrating effect to consider.

For mild intermittent attacks some form of ephedrine (25 mg) repeated every four hours

may suffice. An effective combination is to secure immediate relief by a hand nebulizer containing epinephrine 1-100, isoproterenol 1%, or other drug of choice, inhaled one to three times according to specific directions, followed by rinsing out the mouth to minimize local drying and systemic absorption, followed by the ephedrine tablet which takes about one half hour to become effective but continues its action for four or more hours. It is true that these drugs contribute to hypertension and nervousness which can be minimized by Atarax (Marax) or a barbiturate (Tedral, Amodrine, etc.). It is also true conversely that hypertension due to respiratory effort and anxiety is rapidly controlled when bronchospasm is alleviated.

Overuse of the hand nebulizer is to be condemned because of excessive dryness of the mucous membranes, excessive vasomotor reactions, tendency to cause "adrenalin fastness," and, in some patients, a paradoxical reaction. The latter patients have either increased asthma or persistent asthma after use of the nebulizer. Proof is obtained by abstinence from the nebulizer but strong evidence is provided by demonstrating diminished FEV_1 and FEV_2 one half to one hour after nebulization.[3] Practically every patient in my practice who is permitted to use a hand nebulizer or IPPB at home has been tested in this manner with a Jones Pulmonor to demonstrate that this serious paradoxical reaction does not occur.

In certain patients aspirin relieves asthma, has a hypnotic function and contributes to a sense of well-being. Documentation is difficult but there is evidence that aspirin possesses a minor property of inhibiting bronchoconstriction and other types of smooth muscle contraction caused by bradykinin and similar substances.[4] However, since the drug is a potent sensitizer and so often associated with nasal polypi, its use should be discouraged.

Tranquilizers such as Valium and meprobamate and sedatives such as chloral hydrate and barbiturates are helpful for anxiety and, only in that way, may constitute adjunctive treatment of asthma. They should be carefully prescribed because in many patients existent depression may be aggravated. Atarax, having antiserotonin, antihistamine and antiacetylcholine effects seem more logical to me. However, careful supervision is required since the atropine-like effect of drying secretions by all antihistamines are generally contraindicated in asthma. The regular use of sedatives, cathartics, tonics, vitamins including E, always justify suspicion.

6. Breathing exercises which utilize secondary muscles of respiration to improve the exchange of O_2 and CO_2 also increase bronchial drainage and tend to correct the shallow breathing that most asthmatics use to "avoid wheezing." When mastered by the patient it is a method readily available to him that can abort mild attacks of asthma. The more simple the technique the better and one that I prefer is having the patient in a recumbent position, taking a normal inspiration, and then forceably exhaling so that his abdomen pushes up a book placed on his abdomen; the weight of which varies. Pleasurable exercises within his capacity should also be encouraged.

7. Six to eight glasses of fluid daily supplies adequate hydration and is the most simple form of treatment controlled by the patient and the most often neglected. When adequate, the need for expectorants and cathartics can be minimized or eliminated. When medications are required iodides remain the drug of choice in the form of enseals, saturated solution of potassium iodide, organically bound glycerinated iodide (Organidin) or in combination with ephedrine and theophylline. The hazards of acneform and other dermatoses, lymphadenopathy, hypothyroidism, and sensitization, which in the future might preclude the use of radiopaque contrast media for x-ray studies, should be considered. However, whenever clinically indicated, iodides should not be withheld except for known sensitivity. Glyceral guaiacolate is effective without contraindications and conveniently administered as 2G or Robitussin. I often prefer to use Robitussin-PE which has some vasoconstrictive activity from phenylephrine and good cough suppressant activity can be obtained with Robitussin-DM containing dextromethorphan. Excellent expectorant and liquifactant effects from local hydration of the mucous membranes by steam inhalation can be accomplished by use of a facial sauna. I prefer the Schick type with a face mask.

8. Since 1965 in England and many other parts of the world, cromolyn sodium has been enthusiastically used in the treatment of chronic perennial bronchial asthma. Also a great many clinical studies in this country have provided useful information. Every patient with moderately severe to severe perennial bronchial asthma deserves a 4-6 weeks clinical trial of four daily nebulizations of 20 mg of powdered cromolyn

sodium capsules via a special spinhaler and marketed in this country under the names of Aarane (Syntex) and Intal (Fisons). Animal studies indicate that this drug inhibits the degranulation of sensitized mast cells and, consequently, the release of histamine, slow reacting substance and, perhaps, other chemical mediators of asthma. Cromolyn sodium appears to be remarkably well tolerated but patients should be observed for the rarely reported occurrence of exacerbation of asthma, urticaria, and eosinphilic pneumonia. Use of the drug during pregnancy and before the age of five years is not recommended at this time.

Improvement or benefit means significant diminution of the frequency and severity of asthma and, consequently, reduction in the use of all other drugs, with particular emphasis on the corticosteroids. It has been said that children with extrinsic asthma react best but there are several reports suggesting the same results in adults. Our results from the use of this treatment in 20 patients, all of whom were chosen because they were over 65 years of age, tend to confirm those results. This is, of course, a small series but all had been on maintenance corticosteroids for at least five years.

Six of the 20 patients had excellent results with dramatic effects noted within 72 hours, and certainly during the first week. In all of them maintenance corticosteroids were discontinued by the fourth week of treatment and all showed definite improvement of the vital capacity, FEV_1 and FEV_2 with the Jones Pulmonor. This experience would seem to confirm the theory that the degranulation of mast cells with release of chemical mediators was blocked by cromolyn sodium.

Four patients showed good results toward the end of the fifth and sixth weeks in that the dose of steroids was reduced about in half. Their improvement was slow and progressive which suggests that perhaps another mechanism is involved. There was no change in the pulmonary function studies.

The remaining ten patients desired to continue the drug after the six weeks suggested but felt little or no improvement and could not alter their medication program. It is probably presumptuous of me on the basis of such a small series to mention something that I have not seen reported elsewhere. Most of the patients in whom I thought there was a strong psychogenic element fell into this group. This is not what one would expect with a new treatment.

Cromolyn sodium should be thought of as a prophylactic medication having absolutely no known symptomatic benefits during any stage of asthma. When treatment is initially instituted it should be added to and not substituted for any medication in use at the time.

9. Prompt recognition and treatment of respiratory infections, which almost always produce a superimposed infective bronchitis, is mandatory. Theoretically antibiotics should be specific according to culture and sensitivity tests but one is usually chosen by personal preference and knowledge of which antibiotic is generally effective for that patient or for that series of infections the doctor is treating at that time. It is perhaps more important that whatever antibiotic is chosen that it be administered promptly and for 7-10 days.

There are patients who develop frequent respiratory infections without recognizable foci during the winter months. Many benefit from a daily maintenance 250 mg. capsule of tetracycline or erythromycin. Alternating the two drugs every month or so seems to increase tolerance. Diarrhea, cramps, rectal itching and colitis occur less frequently when an antifungal agent is incorporated with the antibiotic. Sensitization is always possible and drug interactions must be considered. Almost all antibiotics are best administered one hour before or two hours after meals and never with antacids. TAO has been found to be exceptionally effective but is hepatotoxic. It seems generally wise to reserve the penicillins and other potent sensitizing antibiotics for more specific infections.

10. The patient who fails to respond to previously discussed management or who relapses with superimposed acute symptoms needs more intensive treatment. The precipitating factors to be considered are acute respiratory infection (which can be masked by steroids and antibiotics), massive exposure to a specific antigen or irritant, a sudden change to cold, windy and rainy weather, or a stress situation with which he cannot cope whereby hyperreactive bronchi show an exaggerated response to efferent autonomic nervous activity. Overcrowded hospital conditions today make it necessary for the doctor to manage such problems in his office. However, hospitalization is urgently indicated at the first sign of the patient's failure to progressively improve despite intensive management.

An injection of Sus-Phrine 0.1 to 0.3 cc, an

aqueous suspension of epinephrine, is almost as quickly effective as the solution but has a more prolonged effect. The relief so obtained permits aerosolation of distilled water to facilitate production of sputum, followed by an IPPB treatment nebulizing heated Bronchosol 0.5 cc in 2.0 cc of normal saline. Numerous bronchodilating agents are available but both Bronchosol and Bronchometer are beta adrenergic stimulators with predominant beta 2 activity and less affinity for beta 1 and alpha receptors. They have greater bronchodilating effects over the vasopressor reactions of tachycardia and palpitations.[5]

If the patient has a cardiac problem with hypertension or if the preceding program has not been adequate aminophylline in dosage of 250 to 500 mg is given intravenously over a 10 to 15 minute period using a ½″ 25 gauge needle. The first few cc's may be given a little more rapidly until the patient reports a slightly bitter taste and feels some relief. We have nebulized 3 to 5 cc of the intravenous aminophylline solution with the IPPB machine with, at times, remarkable effectiveness. However, it can be irritating and is not repeated. There is also no reason why an intravenous drip could not be used in an office setting, except that constant nursing attention is required.

11. The patient who has needed the preceding program probably requires corticosteroids for the immediate effect or to continue the relief obtained by these procedures. Decadron 2 to 4 mg intravenously or intramuscularly for an almost immediate effect, or Depo-Medrol 80 mg for a sustained effect can be given. Celestone Soluspan is an intermediate acting drug combining a rapid and slowly absorbing combination and the one most frequently used in my office in 1.0 to 2.0 cc doses intramuscularly.

The injectable steroid gives the doctor complete control of the dosage the patient receives and can be repeated at his discretion. If the patient requires too frequent emergency type treatment, the office management might well be considered a failure and oral steroids prescribed. In this event prednisone, which more closely resembles autogenous cortisol and has a short half-life, can be prescribed in doses of 30 to 60 mg (or more) daily with reduction of dosage every 2 to 4 days after desired control is obtained. Again, if exacerbations continue, maintenance prednisone in the lowest possible controlling dose is best administered on an alternate day schedule in the morning. The goal is not elimination of respiratory distress but amelioration to the point where additional safe medications keep the patient comfortable.

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Physician May Not Ethically Require Fee Before Executing Insurance Form

It would be unprofessional conduct for a physician to refuse to complete insurance forms until the patient has paid the physician's bill. This opinion was handed down by Donald O. Meserve, Associate Counsel, Office of the Counsel of the University of the State of New York, State Department of Education, Albany, N.Y. The opinion was requested through the Medical Society of Queens, N.Y.

Mr. Meserve stated that he believed that such refusal by a physician could serve as a basis for disciplinary proceedings against him. Reference: H. Stuart Klopper, Counsel, Medical Society of the County of Queens, Inc.

Note: This opinion was excerpted from *The Citation,* published by the AMA, Vol. 27, No. 11, September 15, 1973. The AMA Judicial Council has not ruled on this opinion.

Tumoral Calcinosis

Case Presentation and Review Of 55 Cases in the Literature

AARON M. LONGACRE, M.D. AND ALLEN L. SHEER, M.D.

Abstract: A new case of tumoral calcinosis is presented and 55 other cases in the medical literature are summarized. Massive multilocular para-articular calcifications — usually soft or cystic—are characteristic for this entity. Absence of severe renal disease, normal bone density and absence of visceral or vascular calcification separate this condition from hypervitaminosis D, milk alkali syndrome, and hyperparathyroidism associated with renal insufficiency.

Tumoral calcinosis is considered a rare entity, yet during the past decade more than a dozen articles with case reports have appeared in the literature. In spite of this, it seems that many practicing physicians remain unaware of this condition and there are cases being overlooked. The purpose of this article is to illustrate a new case and present a concise though comprehensive review of the main features of the previously reported cases.

Case Report

FIRST ADMISSION

A 68-year-old Negro female was admitted to St. Elizabeth's Hospital in Tampa on November 24, 1969 with a large painful draining abscess of the right buttock. This swelling appeared three months before admission. The patient alluded to similar, less extensive swellings in the past, yet was vague regarding details. Mild diabetes, requiring no medication, was recognized for three years.

On physical examination, the patient was acutely ill, toxic and in distress. Mild obesity was noted. The temperature was 104 F, pulse 110 and respirations 24. The blood pressure was 116 systolic, 86 diastolic. There was a massive, fluctuant, warm abscess involving the right buttock. Pelvic and proctoscopic examinations were essentially negative.

The patient's hemoglobin was 11.0 gm per 100 ml. The white cell count was 12,500. The serum electrolytes were normal. The total serum protein was 8.6 gm per 100 ml. The serum albumin was 2.7 gm per 100 ml. The serum alkaline phosphatase was 3.6 (Sigma units). The serum glutamic oxalate transaminase was 47 mU/ml. The serum calcium was 9.2 mg per 100 ml and the serum phosphorus was 4.0 mg per 100 ml. The blood urea nitrogen was 11 mg per 100 ml. Blood glucose determinations during the hospitalization were 210, 78, 83, 75 and 90 mg per 100 ml. A urine specimen gave a +++ test for albumin, a negative test for glucose and a specific gravity determination of 1.017. The urinary sediment was normal.

X-ray examination of the pelvis and hips revealed massive multilocular, calcific densities in the buttocks (Figs. 1, 2). A skeletal survey showed another small calcific deposit in the right shoulder (Fig. 3). An intravenous pyelogram and a barium enema examination were negative. The initial diagnostic impression of the admitting physician was "a deep buttock abscess—possibly a direct extension for a pelvic abscess."

On November 25, 1969 an operation was performed. The operative report read:

"Inspection revealed a large fluctuant mass of the right buttock with hyperpigmentation of the surrounding skin: which was draining thick, purulent material. Exploration of this area revealed a copious amount of thick, purulent, exudate and a large amount of calcified gritty material with multiple abscess pockets and sinus tracts extending to a cavity anteriorly. The entire right posterior buttock appeared to be affected with this ailment."

Following the surgery, and under the influence of Keflin, the fever, pain and swelling subsided. Cultures of the exudate were positive for staphylococcus aureus-coagulase positive, and were negative for acid-fast bacilli and fungi. The pathologist's description of some of the excised material was as follows:

"An irregular 2 x 1 x 1 cm piece of yellowish lightly calcified material resembling a soft piece of sandstone rather than tissue. . . . A similar 2 x1½ cm wedge of material which is somewhat softer and has a rim of fibrous tissue comprising most of the specimen. . . . Diagnosis: Partly calcified, fat necrosis granuloma."

SECOND ADMISSION

On June 6, 1973 the patient was admitted to University Community Hospital because of anorexia, nausea and vomiting, weight loss, anemia, and persistent drainage of chalky material from the right buttock. In the intervening 4½ years she had been hospitalized elsewhere on several occasions for suspected gallbladder disease and congestive heart failure. On one hospitalization the mass in the right shoulder was excised and did not recur, although the masses at the hips persisted.

On this most recent admission, her vital signs were normal although on the 4th and 5th hospital days the temperature spiked to 103.2 and 101.8 degrees respectively. The attending physician described three or four draining ulcers over the right buttock and enlarged, red, weeping ulcers of the left buttock. Cultures of the ulcers were positive for pseudomonas aeruginosa. X-ray showed no recurrence of the right shoulder deposit but considerable increase in size of the left gluteal collection (Fig. 4).

The patient's hemoglobin was 10.1 gm per 100 ml and the white blood cell count was 8,900 with 83% neutrophiles, 4% band forms, 10% lymphocytes, and 3% monocytes. The blood urea nitrogen was 24 mg per 100 ml. The serum calcium and phosphorus were 8.9 and 3.2 mg per 100 ml respectively. The blood sugar was 125 mg%. The uric acid was 5.5 mg%. Total serum protein and albumin were 7.7 gm and 2.1 gm% respectively. The total serum bilirubin was 0.35 mg%. The alkaline phosphatase was 93 mU/ml (normal 30-83). The SGOT was 85 mU/ml (normal 10-50) and the LDH was 95 mU/ml (normal 90-200).

During hospitalization the patient's most distressing problems of anorexia and vomiting subsided and her family pressed for her early release under the assump-

tion that there was little prospect for reversal of her chronic debilitating illness. Consequently she was discharged on supportive therapy and antibiotics without clear understanding of her complicated internal disease process.

Review of Literature and Discussion

In reviewing the various case reports from Duret's[1] original description in 1899 to more recent articles by Baldursson[2] in 1969 and Yaghmai[3] in 1971, one identifies a constellation of special clinical, pathologic and radiographic features which delineate a definite entity. Table 1 summarizes some of the pertinent findings in 56 case reports.

Regarding some of the clinical features, in the majority of cases the disorder was first recognized between the ages of 8 and 21. In only seven cases the disease had its onset after age 40, and ages 2 and 79 represented the extremes. The incidence was distributed about equally between males and females. Forty cases occurred in the colored race, 12 in the white race and in four case reports the race was not given. In 16 instances, a familial occurrence was noted. In 38 cases, the site of involvement was in the vicinity of the buttock, hip or upper thigh. In 28 cases, the elbows were involved. In 12 instances, the shoulders were affected. The jaw and feet were not uncommonly affected, whereas there were no reports of involvement of the knees.

Fig. 1.—(November 1969). Oblique view of right hip. Dense, calcium deposits with varying sized locculated components. Note obvious posterior location of deposits with no direct relationship with bones or joint space. Buttock was painful, greatly swollen and draining creamy material at the time.

Fig. 2.—(November 1969). AP view of left pelvis. Asymptomatic deposits on left similar to those on right side, except that the aggregates are not as dense.

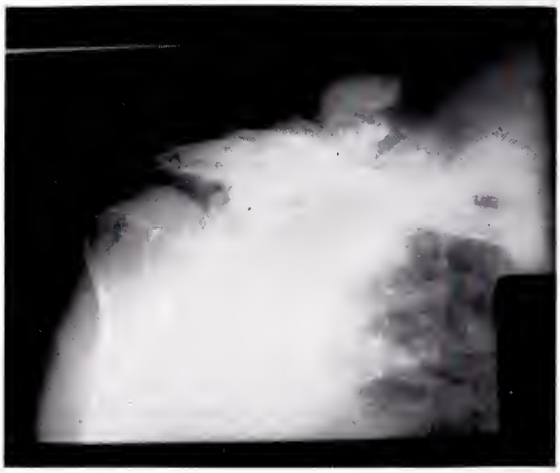

Fig. 3.—(November 1969). AP view of right shoulder. Asymptomatic aggregates above scapula. Rubbery, nontender subcutaneous masses were palpable.

Fig. 4.—(June 1973). AP view of pelvis. Note added accumulation of calcific material about left hip, which now, like the right hip, is symptomatic and draining.

The larger collections had a tendency to erode spontaneously through the skin and drain, with or without superimposed infection. The hip was a common site for infection or drainage, as occurred in the current case report. Thirteen of the 56 reported cases exhibited infection or drainage. In one instance, multiple bouts of infection led to secondary amyloidosis and death.[4] The current case has clinical features of a chronic multisystem disorder arousing suspicion for the same secondary disease process. Recurrence was common after attempted excision. X-ray therapy was employed in four cases[5-7] with a positive response indicated in only one.[5] Although direct restriction of joint motion was uncommon, it was found that massive deposits could hinder mobility about the hip. On occasion, deposits at the elbow impinged directly on the triceps tendon. Sciatica secondary to invasion of the first and second sacral segments was reported by Riemenschneider.[7]

The cause of the condition is not known. Contributory factors may be heredity, trauma, warm climate or excessive heat. A possible inborn error in phosphorus metabolism has been suggested. Hyperphosphatemia in 16 of 56 cases underscored the reason for some detailed metabolic investigation by several workers.[7-10] Hypercalcemia, when present, tends to be mild or intermittent. In the reported cases, the absence of renal insufficiency, with the exception of the single case of amyloidosis,[4] was of significance in terms of the differential diagnosis. The predilection for the colored race and warm climate was illustrated by many reports coming from the southern United States and from some African countries. In southern Africa, Palmer[11] reported having seen approximately 50 cases personally and Koten[12] stated that in 24 years of practice he operated on many cases with this condition. In Kenya, McClatchie[13] summarized 26 cases and presented five in detail.

Pathologically, the aggregates vary from firm or rubbery masses of calcium salts to soft, fluctuant, liquid collections. Chemically, calcium carbonate[14, 5, 6] or calcium phosphate [14-16, 12] can be identified in an albumin suspension.[17] The deposits have fibrous tissue walls and the latter histologically have a combination of collagen fibers, multinucleated giant cells, macrophages and inflammatory cells. According to Thomson[18] the older lesions are prone to be solid, not containing fluid. Lesions with fluid are younger or active and usually possess some accompanying gritty material. In the opinion of Thomson,[18] rather than a basic metabolic disorder, the disease process is more correctly considered a primary calcifying collagenolysis.

Radiographically, when one correlates the characteristic appearance of the calcium deposits and the sites of predilections, the proper diagnosis is not difficult. The deposits, as illustrated particularly in Figures 1, 2 and 4, are dense, cluster-like, multilocular aggregates. Individual globular components usually are sharply outlined and vary considerably in size. Bones and joints are not directly involved. At the shoulders, elbows, and hips, extensor aspects are almost exclusively affected: hence one can appreciate a true silhouette sign, confirming separation of the deposits from the skeletal system. Radiographically, if one can demonstrate the fluid nature of some of the deposits, one is directed toward the proper diagnosis. Interestingly, Annamunthodo[14] obtained an erect film of the hips in his case and demonstrated multiple "fluid levels."

There are other conditions which in part simulate tumoral calcinosis. In addition, there is always the possibility that tumoral calcinosis and another condition productive of soft tissue calcifications coexist.

Somewhat similar massive soft tissue calcifications may occur in hypervitaminosis D,[19-21] milk alkali syndrome,[22, 23] severe renal disease,[24] primary hyperparathyroidism complicated by severe renal damage[25] and sarcoidosis.[26, 27] Seemingly, in all these conditions, if massive soft tissue calcification is present, this is accompanied by visceral calcification generally involving extensive vascular calcification. Also of importance is the presence of abnormal bone mineralization or abnormal bone density in all these other conditions.

There is nothing entirely pathognomonic about the character of the deposits in tumoral calcinosis yet the multilocular components with relatively large individual pockets at the hips are almost unique to this entity. In other conditions mentioned previously, where massive deposits are present, the deposits tend to be more homogeneous and less sharply circumscribed. The latter situation apparently indicates more diffuse interstitial deposition of calcium salts contrasted to the pockets of "milk of calcium" which are commonly associated with tumoral calcinosis. However, to illustrate the lack of clear-cut distinctions, Wermer and associates[23] described a

TABLE 1.

Authors	Year	#	Age of Onset	Sex	Race	Familial	Site of Involvement*	Infection or Drainage	Hyperphosphatemia**	Misc.
Agnew[31]	1961	1	15	M	—		H E	Yes		
Annamunthodo	1960	2	13	F	C		H E	Yes	Yes	Hypercalcemia
Baldursson	1969	3	3	M	C	Yes	E S O		Yes	
		4	4	M	C	Yes	E O	Yes	Yes	Hypercalcemia
		5	5	F	C	Yes	H S O	Yes	Yes	Hypercalcemia
		6	2	M	C	Yes	E		Yes	Hypercalcemia
Barton	1961	7	13	M	C	Yes	H E S O	Yes	Yes	
		8	12	M	C	Yes	H E O		Yes	
Duret	1899	9	12	F	W	Yes	H E S			
		10	16	M	W	Yes				
Ghormley	1942	11	9	M	W	Yes	H E O		Yes	Hypercalcemia
		12	9	F	W	Yes	H O			
		13	9	F	W	Yes	H			
Harkness[32]	1967	14	13	F	C		E	Yes		
		15	15	M	C		H O			
		16	13	F	C		H			
		17	9	F	C		H O E			
		18	10	F	C		E			
		19	4	M	C		H E			
Hartofilakidis[35]	1970	20	4	F			H			
Inclan	1943	21	18	F	C		H		Yes	Hypercalcemia) Radiation Rx.)
		22	17	M	C		H			
		23	10	F	C		E			Radiation Rx.
Jegathesan[36]	1971	24	4	F			H			
Lafferty	1965	25	38	M	W		H S			
Longacre	1973	26	68	F	C		H S	Yes		Amyloidosis?
McClatchie	1969	27	8	F	C		E			
		28	—	F	C		H	Yes		
		29	12	M	C		H E O		Yes	
		30	—	M	C		H			
		31	—	F	C		H E			
McPhaul	1961	32	5	M	C		H O	Yes		
		33	13	M	C	Yes	H E S O	Yes	Yes	
		34	12	M	C	Yes	H E S		Yes	
Palmer	1958	35	—	M	C		H O			
		36	—	M	C		H			
Reddy	1964	37	4	F	C		S			Radiation Rx.
Reed[34]	1965	38	76	F	W		E S			
		39	20	F	C		H	Yes		
		40	5	F	C		O			
		41	56	F	W		O			
Riemenschneider	1952	42	57	F	—		H S O		Yes	Sciatica
Smit[33]	1967	43	10	M	C		H O	Yes		
		44	14	F	C		E		Yes	
Thomson, JEM	1949	45	13	M	C	Yes	H E			
		46	12	M	C	Yes	H E S O	Yes		Radiation Rx.) Amyloidosis)
		47	11	M	C	Yes	H E			
Thomson, JG		48	40	F	C		H			
		49	12	F	C		E			
		50	65	F	C		H			
		51	79	M	C		H			
Wilbur	1968	52	5	M	C		E O		Yes	
Yaghmai	1971	53	16	M	W		H			
		54	23	F	W		H	Yes		
		55	13	M	W		H E			
		56	31	M	W		O			

*Sites of Involvement
H—Hip, Buttock or Upper Thigh
S—Shoulder
E—Elbow
O—Others

**Hyperphosphatemia
Above 4.5 mg per 100 ml

case of milk alkali syndrome with massive calcification in the vicinity of the scapula where the excised mass was found to be cystic, containing thin, "seropurulent" material. The report of the microscopic examination is really no different from the description of tumoral calcinosis. Furthermore, Chaplin,[19] in his reports of vitamin D intoxication, described several cases of soft, fluctuant masses. In one instance, milky viscous fluid was identified. Finally, soft tissue deposits in calcific bursitis may be soft and cystic[28, 29] but they do not attain the large size or the massive multilocular structure common to tumoral calcinosis.

Two case reports of tumoral calcinosis not listed in Table 1 also present problems in terms of precise classification. In the article by Barton and Reeves,[15] a 32-year-old white female with extensive soft tissue calcification of the shoulder, elbows, hips and feet was presented. In this instance, azotemia, nephrocalcinosis and vascular calcification preceded or accompanied the problem of soft tissue calcification. Properly, these latter features, plus the "homogenous" character of the hip deposits, should exclude this case. Another case report by Lauchenauer[30] presents more of a dilemma. Here a 60-year-old female had multiple soft tissue deposits with "grape-like clusters," "a fistulous tract" and "creamy white fluid." These features certainly resemble tumoral calcinosis. Other findings were hypercalcemia, renal insufficiency, small kidneys and renal calculi. Perhaps two different conditions promoting soft tissue calcification coexisted. In any event, until more clarification is forthcoming, it is probably best to exclude those cases where massive soft tissue calcification is present with azotemia, visceral calcification or an abnormal skeletal density unless the massive depots clearly antedate the other events, as is Thomson's[4] case report.

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Special Articles

Florida's Camps for Children and Youth With Diabetes

Arlan L. Rosenbloom, M.D., Milton S. Grossman, M.D. and John I. Malone, M.D.

Children and youth with diabetes face the harsh task of learning to live with a hidden malady. Difficult for even the experts to comprehend, diabetes is shrouded in popular myths and is threatening to a youngster's self-worth. Children and their families require education to understand the disorder itself, their emotional reactions to it and how these feelings can in turn affect control of the diabetes.[1]

Florida's Camp for Children and Youth with Diabetes[2] has become an important element in the construction of a comprehensive program for these youngsters. Certain unique features of the camp setting have dispelled a distaste for segregating kids with diabetes and potentially reinforcing their sense of abnormality.[3] Of prime importance has been the feedback of the youngsters themselves who tell us that camp permits them to mature in their understanding and technical skills. With others who have the same problems they can work through their self-pity, depression, anger and guilt.[4]

Among the novel opportunities provided by the camp program are:[5,6]

The ability to teach youngsters about their diabetes in a natural and friendly setting, to monitor their various behaviors in a nonblaming situation;

The participation in an unmodified camp program which supports the idea that the potential for complete life exists for individuals with diabetes;

The occasions for "rapping" with experts who can assist in the expression of feelings and help dispel popular myths about diabetes and the people who have it;

The prolonged observation by and involvement with medical staff permitting the unraveling of management and emotional problems difficult to sort out in the clinic or hospital;

The education of children and parents away from the overdependency (and manipulation) common in families with childhood diabetes;

The teaching of parents, in special parents' day programs, to better understand diabetes and the needs of their children;

Immersion of physicians, nurses and other personnel in a helping environment that tends to obliterate rigid health care roles and emphasize personal skill and understanding;

Aggregation of large numbers of youngsters with diabetes for investigation without the variables imposed by the hospital setting.

Background

Florida's camp program began in 1962 with 41 youngsters ten to 14 years of age at a YMCA camp near Keystone Heights. The original idea of utilizing an established camp program with its cadre of camping professionals has been retained to the present.[2] Another basic and persisting tenet has been that the camp programs subserve the teaching role of the supporting institutions[2] and, consequently, that all professional and student participation be voluntary.

In 1969 the camp moved to a more modern facility close to Gainesville, making possible participation of more health profession trainees and students who could live at home. In spring 1970 the camp was incorporated (Florida Camp for Children with Diabetes, Inc.) not-for-profit to

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develop a structure for perpetuation of the program, to facilitate gifts and to expand lay and professional participation and leadership. The first corporation meeting was held at camp on August 15, 1970, when, in addition to ratifying the bylaws, the directors approved an expansion to two sessions of two weeks each and the development of a youth program.

In March 1971 a weekend retreat was held at camp to reevaluate the total program and to explore goals for the youth camp. Older campers, counselors, medical and nursing directors and YMCA staff participated. The importance of the camp program to the youngsters was reemphasized. The intensity of the campers' gratitude for the opportunities given them to learn to master their diabetes and to grow, independent of their parents, was touching and an inspiration to the adults present. Though we had intended to have 15 to 20-year-olds at the youth camp, the youngsters convinced us that early adolescence, corresponding to an age of 13 or 14, was the turning point in needs and interests. They argued that the younger campers required basic education and the acquisition of skills while the adolescent needed emphasis on personal growth and social problems related to his or her diabetes.

The 1971 sessions served 145 youngsters seven to 20 years of age, an increase of 45 over the eight to 14 year enrollment in the single two-week session in 1970. In 1972 enrollment in the youth camp doubled to 55 campers; the children's camp enrolled 132. The capacity of the YMCA facilities was clearly exceeded in 1972. Furthermore, the YMCA elected to restrict enrollment to those under 14 years because of the inability to cope with the older adolescents at camp. As an emergency measure, the facilities at the University of Florida campus were used for the 1973 youth session, which was held at the same time as the single children's session at the YMCA camp. These sessions served a record number of campers, 113 at the children's camp and 74 at the youth camp.

For 1974 a facility has been secured that will permit accommodating all 200 children and youth campers during the same two-week period.

The Camp Program

The present organization involves a complex of statewide medical centers (University of Florida, University of South Florida, University of Miami, Mt. Sinai Hospital of Miami), voluntary health agencies (National Foundation/March of Dimes, Juvenile Diabetes Foundation, Florida Diabetes Association) and government agencies (Division of Children's Medical Services, Division of Vocational Rehabilitation). Medical supplies are largely donated and sponsorship of campers whose families are unable to pay (approximately 50%) comes from service and professional clubs, United Funds, private donors, corporate donors, military Medicare and the voluntary and governmental agencies previously noted.

In early spring a brochure is mailed to all former campers and all Florida physicians announcing the camp sessions. A card is included for requesting an application. The application includes a physician's referral form to provide basic information about the child. Parents are sent instructions and rules about camp a month before enrollment; included is a form on which to record urine testing and other data for the two weeks prior to camp.

Orientation sessions for resident camp staff are imperative to familiarize them with the special problems and needs of children and youth with diabetes and to prevent manipulative use of the diabetes by the youngsters. The day before camp opens a program for both medical and camp staffs is held to supply the basic technical expertise needed and to develop awareness of the goals and design of the camp program. Folders are available on each registered child, permitting cabin teams to discuss the information on the application forms, to become familiar with the record-keeping system and with each other. This exploration and further instruction are continued on the morning of admission day.

Youngsters are checked in by the camp and medical administrators and immediately go to their cabins where counselors involve them in introductions and activities. Parents, meanwhile, are interviewed by the cabin medical staff who review the two-week precamp record and take a detailed nursing history. At 30- to 60-minute intervals the parents are assembled for an informal exchange with the medical directors; this session emphasizes the necessity of ignoring pleas to "come and get me" in the children's letters and expresses the directors' willingness to talk by telephone with concerned parents. At this get-together parents are able to express their overprotective fears, get testimonial support from parents of repeat campers and gain a feeling of

confidence in the camp's ability to care for their youngsters.

It is important for parents and camp and medical staff to recognize that children who have no experience with separation are often unable to work through it without help. Severe homesickness is not necessarily a sign of overprotectiveness or the child's fears that his unstable family will disintegrate or abandon him; it may simply reflect family closeness. Explaining in terms the child can understand that everyone is homesick when away from home, that there is no cure—only distraction, and that telephone calls make it worse, must be combined with firm pressure to participate and the downplaying of minor somatic complaints. Unless homesickness is controlled compassionately, but firmly, camp morale is imperiled and the depression is reflected in difficulties with the diabetic control.[1]

Research

Research on various aspects of childhood diabetes has been considered a legitimate pursuit of the various professionals participating in camp. During the past four years alone, studies have included: effects of glucagon therapy on calcium and magnesium concentration,[7] utility of urine tests measuring up to 10% glucosuria,[8] control criteria,[9, 10] coping mechanisms and family dynamics,[4] acquisition of knowledge, use of U 100 concentrations of insulin,[11] renal function in childhood diabetes,[12] field trial of reflectance meter-test strip glucose measurement systems, and natural history of diabetes in families of affected children.[13-18] All investigations have fulfilled the criteria that they must not appreciably interfere with the camp program and be of potential value in our understanding of children with diabetes. Procedures beyond the usual blood and urine tests are done with the informed consent of the parent and the child.

Management

When all campers have been registered and parents interviewed and bade farewell, the medical staff is faced with its first decisions. Based on the two-week precamp record, nursing history, application medical form and, in the case of most of the children and all of the youth, an interview with the camper, the staff must decide whether to recommend a change in insulin dose or form and must outline a set of goals for the camper during the subsequent two weeks. An antomatic reduction in insulin dosage to allow for increased exercise in camp[2] fails to consider the child's previous control state,[9] frequent occurrence of increased hyperglycemia during the first days of camp due to anxiety, and the youngster's precamp activity level. All campers are now taught to use U 100 insulin — no other concentration or equipment is available in camp.

No attempt is made to control diet tightly, in keeping with long-standing pediatric practice[19] and current recommendations of the American Diabetes Association.[20] Principles of good nutrition are taught by dieticians and others, not as "diabetic diets" but as important health principles. For example, "sweets" and animal fats are discouraged and vegetables and fresh fruits promoted. Youngsters with obvious nutritional disturbances (gorging, obesity, undernutrition) are considered individually, and the effects of their diabetes treatment, emotional and socioeconomic factors explored. Snacks are provided between meals and at bedtime.

The two-drop Clinitest[R] tablet method of urine glucose testing has been taught for the past eight years at camp.[8, 9] Other methods (Testape[R], five-drop Clinitest[R], Clinistix[R], Diastix[R]) are quite sensitive, but measure only up to 2%, a level not particularly high for children. Using the Clinitest[R] tablet, two drops of urine with 10 drops of water and a special color chart (not the one packaged with the tablets), concentrations up to 5% are measurable. With one drop of urine and 11 of water, concentrations to 10% can be determined. This system is not only more reliable for spot checks but also can be used to quantitate total urine glucose output in 6-, 8-, 12- or 24-hour aliquots. At camp urine is tested on a second-voided, prebreakfast specimen and on first-voided specimens before lunch, before supper and at bedtime. Glucose concentration in second-voided urine samples correlates no better with concomitant blood glucose determinations than does glucosuria in first-voided specimens.[10] Routine daily 24-hour urine collections, though valuable for monitoring control, have not been feasible in the camp setting.

No restrictions are placed on activity or appropriate discipline. However, certain rules must be emphasized. Someone must be present in any group who understands the signs (especially early behavior change) of reactions and knows what to do and has the supplies (sugar, glucagon). This may be a counselor with diabetes or a medi-

cal staff member. There can be no activity or discipline that involves unsupervised solitude. Finally, hunger must be respected and denial of snacks or meals is forbidden as a disciplinary measure.

Teaching Program

The perennial excitement of camp remains unmitigated because of the concentrated and intense educational experience. All of the participants, from campers to professional staff, participate in this learning adventure. The most experienced physician and the youngest camper learn more about children with diabetes in this two-week period than during the rest of the year, and along the way they learn much about each other in a way that our more conventional settings impede.

The professional staff of the 1973 camps included 75 participants and supervisors. Some pediatric houseofficers and nurses were present for less than the entire two-week period; thus, the following list includes only full-time participants and combines the time of the others for an expression of equivalence to full sessions. For example, two nurses each spending a week at camp will be listed as one nurse.

Medical Directors	4½	Nursing Students	12
Nursing Directors	3	Psychology Interns	2
Pediatric House-Officers	6	Occupational Therapist	1
Medical Students	7½	Occupational Therapy Students	3
Dental Students	6	Laboratory Personnel	3
Nurses	6	Dietary Instructors/ Interns	3

Total Full-Time Equivalents = 57

Eight and one half of this personnel were from Mt. Sinai Hospital of Greater Miami (including 1½ medical directors and seven nurses). One medical director was from the University of South Florida, a pediatric houseofficer from the University of Miami. The rest were from the University of Florida with the exception of three nursing students from various schools in Florida.

All except dietary, psychology and laboratory personnel were assigned a small group of youngsters as teams of two or three students, with a pediatric houseofficer relating to two or three teams. The times of teaching involvement with the youngsters seven to 12 were (1) the hour before breakfast when urine testing, dose decision making and insulin handling could be checked, (2) other urine testing periods, (3) mealtimes when good nutrition could be discussed and demonstrated, (4) an assigned 30-minute class for teaching geared to the group's needs, and (5) the rest hour after lunch. Free time was available for individual attention as needed.

Topics to be covered with the campers and the teaching pace in each group were to be flexible but the following areas were expected to be covered: urine testing and interpretation of results; ketones: what they mean and what to do about them; insulin injection techniques, site rotation; U 100 insulin—why?; recognizing and managing insulin reactions; when to change the insulin dose; eating for health; dental hygiene. In short, the foundations for self-management were laid.

The youth program was less structured and centered around individual problems and rap sessions.

Medical staff education included daily formal lectures or problem conferences and chart rounds. Together with the orientation program, but excluding numerous hours of informal teaching in the infirmary and around camp, the teaching hours numbered 34 for the two-week period.

The educational experience of the professional staff was well described by one of the medical students:

> The learning experience encountered . . . cannot be matched by any other experience in medical school. . . . There were daily teaching sessions from which basic knowledge was obtained. These sessions were very informal and everyone participated. . . .
>
> As in any learning situation personal experience and responsibility . . . help one understand the mechanism, evaluation and treatment. . . .
>
> Another drive to learn in . . . camp is the need to really understand the details of diabetes in order to teach the kids . . . in a form that they can understand. . . .
>
> The last learning experience and probably the one that cannot be matched by anything else in medical education is the true feeling for the emotions and tensions a child experiences when he or she lives with diabetes everyday. . . . I worked with 14 boys ages 9 to 10 and they taught me lessons I will never forget about how children handle an illness that never goes away, that they must wake up to each morning.

Education of parents is pursued on the day before camp closes with lectures by the medical and nursing directors and demonstrations by the youngsters themselves. A record 175 parents attended the Parents' Day program in 1973. On Parents' Day and discharge day, parents review the camp experience and observations with the medical staff involved in their youngsters' care. They are given a copy of the records indicating urine tests, blood tests, insulin dose, and significant events (e.g., reactions), a packet of instructional

materials and a letter from the staff emphasizing what has been learned by the youngster in camp and suggesting they help him or her sustain these skills and independence.

The final teaching function of camp is the transmittal of what we have learned about the youngster to his or her physician, along with information about what the camp teaching has been. This is extremely important because the youngsters need these teachings reinforced from time to time. Without this reinforcement, the concept that no food is "poison" for those with diabetes is misconstrued to mean that they can eat unlimited quantities of candy. The physician is sent a copy of the medical record for the two weeks of camp, a letter from the staff indicating any changes in insulin dose or type and the reason for the changes, goals met and those requiring further guidance, misconceptions and confused areas parents and/or child had or still have, ways parents can best help their child and a summary of the dental inventory. He is also sent a general letter explaining the camp program and special aspects, such as the use of U 100 insulin and the two-drop Clinitest[R] system, and inviting his or her comments. A two-drop color chart and our instruction manual for children complete the physician's packet.

Future

The 1974 session will be at Lake Swan Camp, 17 miles east of Gainesville. This well-kept facility has two crystal-clear lakes and a program that centers around water sports. During the two-week period, July 14-27, we will be able to accommodate all 200 anticipated children and youth campers. Cabin counselors will be selected from alumni of our camp program. Though activities and hours will differ somewhat for the youth group, we anticipate a wholesome measure of mixing of the age groups. This will have the beneficial effect of placing the older campers in a position of role models and teachers, which can be used to build their own self-esteem.

The potential of the camp program and concept has yet to be fulfilled. Ongoing evaluation of the effects of the effort needs to progress beyond the anecdotal. Practicing physicians who see children and youth with diabetes could profit from any amount of time involved in camp. Weekend sessions need to be considered for parents, youngsters and health professionals to supplement the annual effort. Two weeks is a short time for this kind of program, and we need to consider extending it.

Conclusion

This presentation is not meant to convey an obsession with the disorder diabetes; the focus of our interest is the youngster and our object to educate him and those around him (parents, health workers, teachers) to the real imperatives of this problem. A well-organized diabetes camp program can communicate the necessary skills and understanding without impeding the opportunities for vigorous activity and self-exploration with other youngsters who have similar problems.

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Disaster Drill - '73

Jane Whitney, LPN

Twenty-eight students were rushed to the hospital via emergency rescue units and ambulances following an early morning light plane crash onto a football field. Police and firemen arrived on the scene as students lay "injured."

No one was hurt. It was a mock disaster drill which had begun as a plan ordinarily would, simple, concrete, precise. As details were more carefully worked out, the procedure assumed seemingly insurmountable proportions. Parts of the planning were amusing, but the seriousness of a real situation was always foremost in our minds.

First, we decided on a daytime drill. What if a real disaster occurred during the hours busiest for the hospital, doctors and community. Immediate response would be essential.

What type of a disaster would we have? Because of our proximity to Cape Kennedy, we had always thought in terms of adult casualties. This time we centered our thoughts on junior high students old enough to understand and learn, ready to role-play and participate in anything exciting.

We received permission from the hospital administrator to pursue our plan. Via telephone, we received permission from the school board to approach the principal of the junior high school. As we anticipated some hysteria from parents of school-aged children, we were prepared to explain every detail: noise and confusion would be kept to a minimum; there would be no sirens; we would arrive with Civil Defense and apply the moulage, one hour later, we'd call the drill; ambulances and police would arrive, pick up the children and whisk them off to the hospital without fanfare. They would be back at school for lunch.

The plan was approved.

Broken Arrow

Procedures at the hospital were updated, revised and distributed to every unit. "Broken Arrow," our code for an external disaster, was further programmed in the inservice department via films and a review of the procedure. Attendance was required by all hospital personnel with no exceptions.

We called a meeting with our chief engineer, representatives of the fire and police departments, Civil Defense and hospital administrative personnel. It was a disaster. Our little drill would not be "quiet" for the following reasons:

1. As communications at the police and fire departments are electronically transmitted, equipment is immediately sent to the scene. There is no way to put "mock" into the procedure; thus sirens for, to them, it would be the real thing.

2. When alarms are sounded in the emergency services, communications are automatically sent out to the news media; therefore, reporters, cameras, radio announcements.

3. If there were no visible signs of a fire, the fire department would thoroughly investigate the scene, after calling off other emergency services.

4. Civil Defense representatives added that to further the dramatics, they would have a fireman with full gear "collapse." "We'll see how alert the triage team is," they commented.

The meeting ended. We shook our heads at what we'd gotten into. How, above all, could we explain to the principal that our simple little drill was being blown into a full scale disaster drill with a very active, very concerned, and very learned civil defense leader in command.

After more thought, the fire department called and stated that from their experience, involving them with sirens and a fire would indeed cause hysteria and might result in a true disaster. They preferred not to participate. We now could be more gentle with our "new" plan to the principal. We also got the feeling that the police were having second thoughts.

A meeting of officials was held the next day with the principal. He was totally committed and felt that it would be an excellent learning experience for his students and teachers. It was decided that there would be no sirens, and the police would actively participate.

A 9th grade English class would comprise our "victims." They would be "wounded" in a light plane crash. The plane crash was natural as the

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school is within flight range of an airport. It is of modern architecture, an open space plan without windows. The principal was concerned with how the students and teachers would get out of the building. He would evacuate the school at the time of the drill.

Because the disaster victims would be evacuated through the cafeteria, a critical problem presented itself. The cafeteria led directly to the faculty parking lot. How would emergency vehicles get within close proximity of the victims?

Another decision at the meeting was to have one member of the planning group alert all news media early on the morning of the drill. They would be alerted only to the approximate area and to a "MOCK" disaster drill.

Another meeting was called one week before the drill by our chief engineer who wanted to re-coordinate with the fire department in, if possible.

Several things were changed and new insights gained:

1. The local fire department had never held a drill of this type. Personnel had never been a triage team.

2. The fire and police chiefs expressed concern about a drill of the magnitude we were planning taking place in a school. While their responsibility is to protect the citizens and learn, as we would, they felt it might result in real tragedy.

3. The major portion of the plan was saved with only the site being changed. The high school football field north of the city would be used. The children would be transported by school bus to the field and have the moullage applied there.

4. The school would lose its chance to have an evacuation drill and mass hysteria would be avoided in all probability.

Our inservice director talked with the group of students who would participate. They were given permission slips to have signed by their parents. It gave the purpose, the week, and requested that the student have clothes that could be torn, or burned, if necessary. All were signed but one.

A moulage class was conducted by a civil defense expert from Jacksonville. Attended by nurses, volunteers from the fire department (who applied the moullage for our drill) and other hospital personnel, this class taught us how to apply burns, simulate fractures, lacerations, amputations and shock. It looked very real, and it was two days before drill time.

Mock Disaster

Wednesday arrived; our mock disaster was really going to happen.

The inservice director unlocked the gates to the field at 7:30 a.m. I called the news media and MOCK was especially emphasized. At 8:20 a.m., the students arrived, eager, excited, apprehensive.

The young group was asked, once more, if any were allergic to make-up, or had fainting or epileptic spells. No affirmative replies.

After three or four had been made up, one boy, who was being instructed in how to act with "his type injury" "felt bad." In attempting to get him to fresh air, he fainted. An understanding, very efficient ambulance attendant who most fortunately had his first aid kit, assisted and cared for him.

On to the football field and the victims were placed at strategic spots. Having checked thoroughly with the kids, we felt that all was secured and went to the hospital.

"ATTENTION, ALL EMPLOYEES—EXECUTE BROKEN ARROW—THIS IS A DRILL" went out three times throughout the hospital and was repeated three times.

The chief of staff and emergency room staff were alert for the first victims. Maintenance was starting to set-up a triage at the entrance to the hospital, and clearing all traffic from the area. Nurses were on their way from home, they came from the floors, all taking the stations they had been assigned.

All doors were blocked and guarded.

The first ambulance rolled in; four "injured" were taken to ER stretchers, the first one so thoroughly examined that the doctor removed all his clothing but his shorts.

The children arrived at frequent intervals, the most severely injured first. We were surprised to hear a siren or two. If the children were to be in shock, they played their parts well, giving no response to questions. It was no joke to them or the staff. They were tagged as to the department to go for diagnosis, treatment, admission or treatment and release.

The doctors responded immediately. X-ray became bogged at one point. Everywhere one looked, there were nurses with blood pressure

cuffs, putting on bandages; admitting clerks getting information, doctors bending over stretchers.

All Clear

The drill was called at 10:20 a.m. At 11:10 a.m. all "victims" had been sent for treatment. The "all clear" was given by our chief of staff, and announced to hospital personnel. Heads suddenly popped up from previously very quiet bodies. The "injured" had been completely entranced, very impressed.

To key them down, we took them to the classroom and with soap, towels and elbow grease, took off their masquerade. Off to the cafeteria, and did they eat! We further acquainted them with the hospital with a 45 minute sound and slide program that we show to new employees and public groups. This was followed by a question and answer period.

We feel our drill was very successful. There are many areas for improvement, of course, but we learned much, we worked hard and we feel everyone benefited greatly. We also feel our community knows we are taking one more step toward serving it to the very best of our ability.

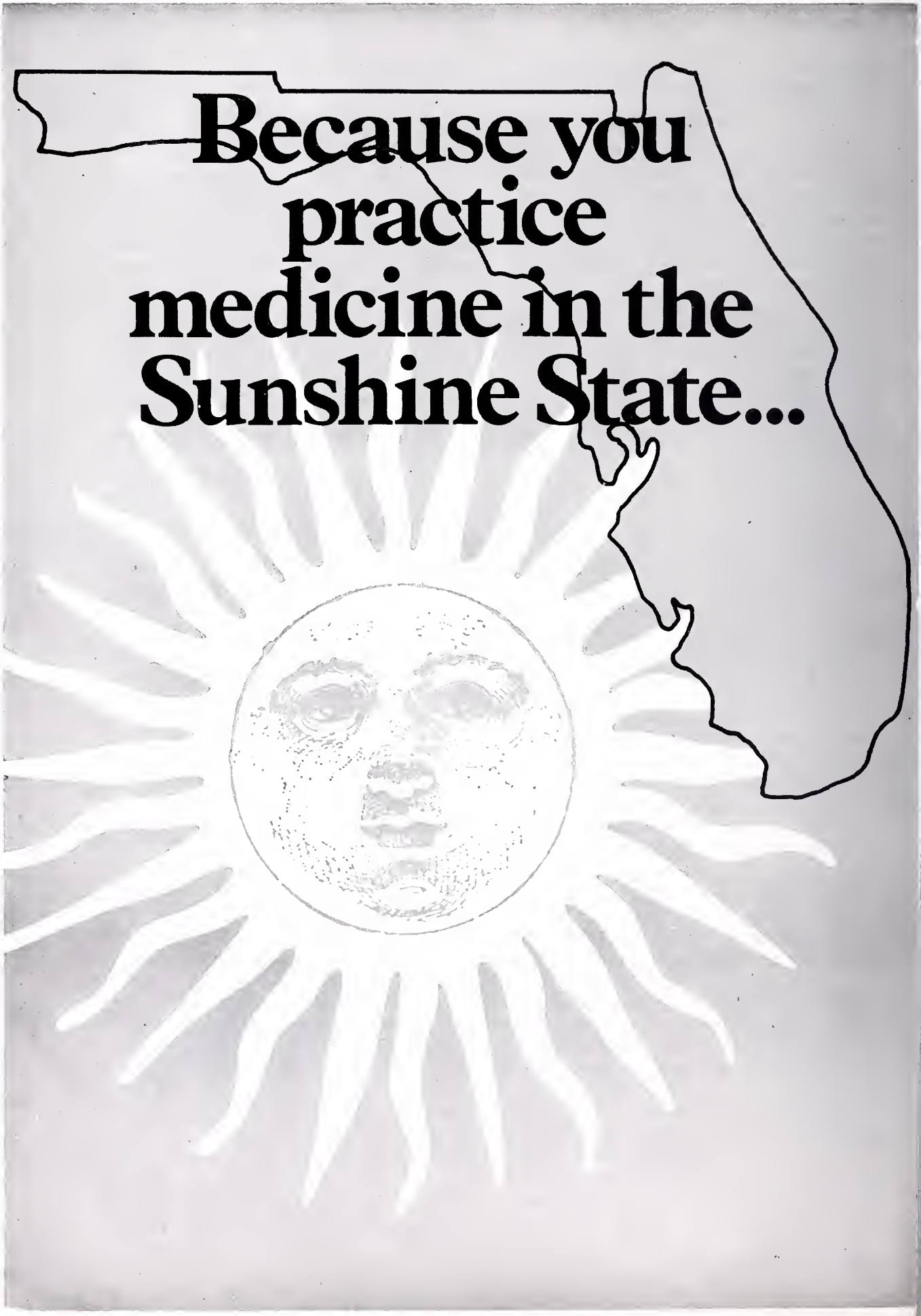
Our drill was on a Wednesday. Proof of its success was an unfortunate event on Sunday. Within five minutes of each other, two dune buggy accidents brought numerous young patients to the ER. Eight doctors responded immediately to the page, staff from the lab, x-ray and inhalation therapy helped. It was a total team effort—effective, efficient. Perhaps it was helped with the freshness of mind of the young "victims" of the drill earlier in the week.

▶ Mrs. Whitney, 4700 Barna Avenue, Titusville 32780.

Medicaid

Medicaid/Medicare, which is which? Where do you go to find out about these programs? It appears that there is some confusion between the two kinds of protection. The confusion probably stems from the fact that on January 1st the Social Security Administration, which is responsible for Medicare, took over the responsibility for making cash payments to the aged, blind, and disabled. This was formerly the function of the Florida Division of Family Services.

Since the day after New Year's, the Social Security offices have been swamped with phone calls from doctors and hospitals asking about a patient's entitlement to Medicaid and wanting explanations of coverage. All Medicaid questions should be directed to the nearest Division of Family Services office. The Social Security Administration has only the responsibility to determine the individual's right to a cash benefit. When the individual is found entitled to a monthly check, the State of Florida is notified and the state certifies an individual's eligibility for Medicaid and mails the Medicaid card, which has the medicine card attached.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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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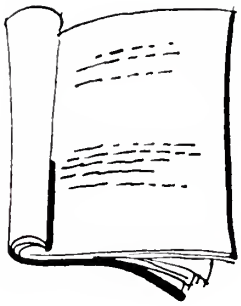

Others Are Saying

Breast Biopsy — An Outpatient Procedure?

Richard M. Fleming, M.D.

Recently there has been increasing interest in outpatient breast biopsies under local anesthesia. Proponents of this method cite these advantages: 1) Reduction of medical and hospital cost; 2) Avoidance of general anesthesia; 3) Patient participation in the decision as to subsequent treatment if the biopsy reveals a malignancy.

Everyone will endorse the aim of the first two points. As to the third point, it has been my experience that the overwhelming majority of women are not only willing to accept their surgeon's advice but are anxious for him to make the decision for them. For the patient who wishes to make her own decision, however, the various treatment alternatives can be discussed and a specific treatment decided upon pending pathological confirmation of a malignancy.

The criteria for outpatient breast biopsy are: 1) Tumor superficially situated without stigmata of malignant disease; 2) Tumor is less than 3 cm. in diameter and can be completely excised; 3) The surgeon is responsible for definitive care if the lesion is malignant; 4) The procedure is done under operating room conditions and a hospital bed and operating room time is available within a reasonable time following biopsy; 5) Patient is psychologically adaptable to the procedure; 6) Mammograms are not diagnostic or highly suspicious of malignant disease.

Contraindications to excision under local anesthesia are: 1) Deeply situated mass or a mass seen on mammograms, but not palpable; 2) Vague mass or diffuse induration; 3) Mass which does not lend itself to complete excision; 4) Biopsy by a physician who is not prepared to do a definitive operation if the lesion is malignant.

A nonindication, rather than a contraindication, is excision of a mass thought to be a cyst. Although there is a slightly higher incidence of carcinoma associated with cystic mastitis, there is no evidence to indicate that occult malignancy is more frequently associated with the "dominant cyst" of the breast than with other cystic areas. These cysts can best be taken care of by simple aspiration. If the mass doesn't disappear completely, if the fluid is bloody or if there is residual induration, a formal biopsy can then be carried out.

Complications of outpatient breast biopsy: 1) Hematoma and ecchymosis; 2) Infection; 3) Local spread of tumor or opening of new plane for spread; 4) Failure to remove the target area.

When the procedure is conducted as a bona fide surgical operation these complications are unlikely.

In summary: Outpatient breast biopsies under local anesthesia may be safely done under certain circumstances. The mass should be superficially located, relatively small and should lend itself to complete excision. The procedure should be done under operating room conditions by the surgeon who will handle the definitive treatment should the lesion prove to be malignant. One should ascertain that operating room time is available, should further surgery be indicated, prior to performing the biopsy, and the patient should be prepared to go ahead with surgery within a few days if the biopsy is positive. Highly suspicious tumors are best handled in the conventional manner. Cysts usually do not require excision since they can be treated by aspiration.

▶ Dr. Fleming, 1688 Meridian Avenue, Miami Beach 33139.

Reprinted from Miami Medicine, October 1973.

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Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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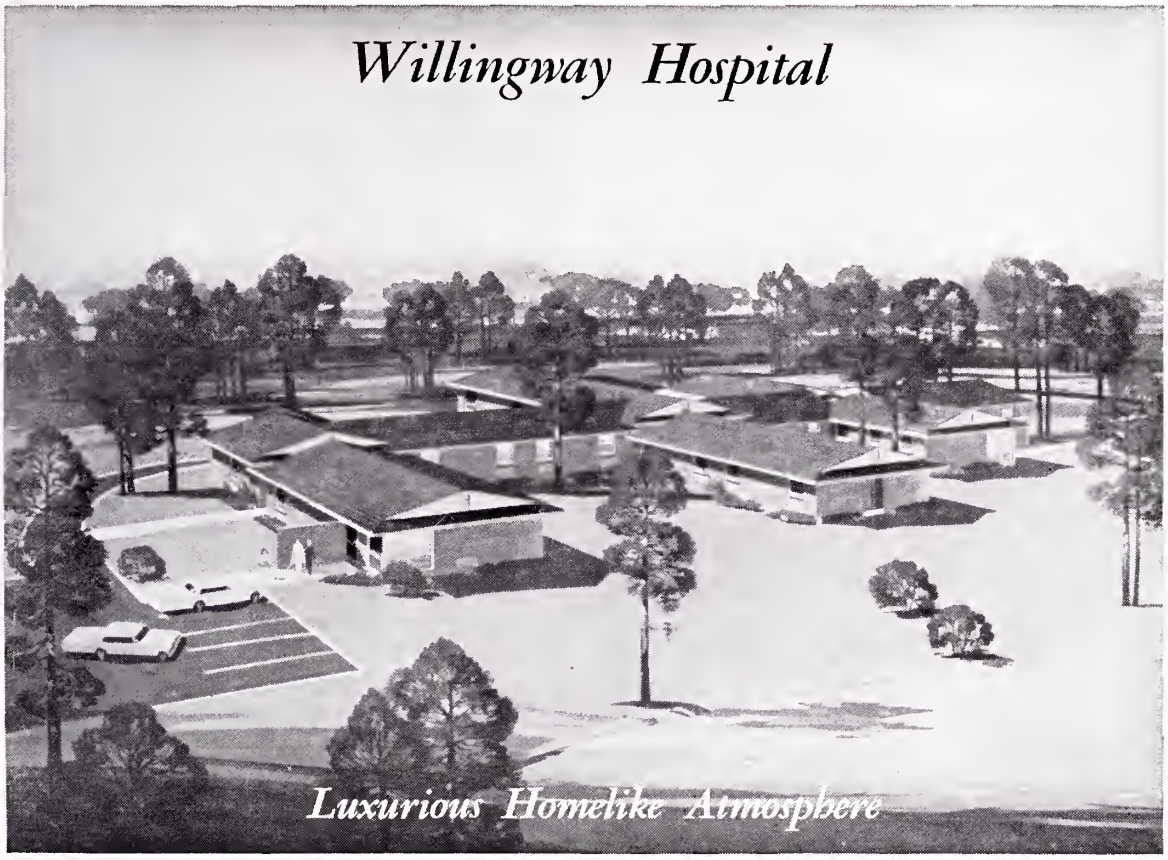

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Editorials

A Challenge to Traditional Health Delivery Systems

A massive experiment, signed into law by the president, will test patient and physician acceptance of prepaid group health care delivery. Almost unnoticed in the press of top priority energy legislation, the major health bill of the year and perhaps one of the most far reaching, provides $375 million over five years to help in the establishment of Health Maintenance Organizations across the country. Political leaders, ears tuned to voter demands, believe that the call for a combination of quality and economy in health care can no longer go unrecognized, which is one reason why such programs are receiving wide public attention. Whether the HMO is the medical wave of the future or just a passing fancy, no one can predict but in the profession's best interest all should familiarize themselves and know about the plan before condemning it, for in the end, it is the physician who is most qualified to pass judgment.

With supervision by the Assistant Secretary of Health, each HMO must meet a long list of federal standards with required basic benefits such as physician and hospital services, mental health care and treatment for drug abuse and alcoholism; as well as stay open 24 hours a day, provide open enrollment, and set up inducements to attract people from poor neighborhoods. Employers are required to offer workers an HMO option when existing contracts for health insurance expire. Regulations and guidelines are to be published by March 31st, making nonprofit and for profit organizations eligible, with funds available for feasibility studies, planning and development. Initial operations will be covered for a maximum of three years. For the current fiscal year, 50 new HMOs will be underwritten with $25 million available. Allegedly, there is at present, no functioning plan that conforms to these regulations, however, prepaid health care operations (HMO prototypes) come in many different forms. One run by physicians in Sacramento, providing contractual care for patients under MediCal, is pleasing to almost everyone. With 37,000 Medicaid patients out of a maximum 56,000 eligible, physicians receive higher fees than the regular Medicaid program. These physicians, previously prompted by red tape, limitations of two office visits per month, prior authorization required for hospital admissions and a restricted formulary for drugs, persuaded the state legislature to allow their foundation to accept prepaid patients while at the same time, accepting some of the financial risk of overutilization. Almost all the doctors in the Sacramento area cooperated in organizing to operate under local medical society sponsorship. Incentives to join include the avoided expense of filling out complicated forms, reversal of the restrictions listed above and the fact that each patient is free to choose his own provider of care. What was new is the prepayment idea and physicians sharing financial risk of overutilization to be controlled by their own peer review.

Midway between Baltimore and Washington, in Columbia, Maryland, another plan has about 15,000 members who pay $21 a month for an individual ($40 for husband and wife) to receive continuous access to a complete range of medical services, including hospital care and prescription drugs. Developed by the Johns Hopkins Medical Institute and the Connecticut General Life Insurance Company, the program has three basic components—insurance carriers to develop and market prepaid health plans, physicians to provide professional services and a hospital to provide the physical setting. Membership is open to anyone. Premiums are paid in advance and the paid up member obtains full and immediate use of all planned services. Newly enrolled members are asked to come in for a comprehensive health

assessment examination which is updated periodically. After that, the facilities can be used as would those of a fee-for-service physician, a nominal fee of $2 being charged for each office visit. The program has kept down hospital utilization compared to other prepaid group plans averaging 390 to 420 days under Blue Cross while commercial insurance carriers average double that. The plan is operating in the red at the present time, the major problem being securing new members.

Escalating costs for HMOs from overstaffing and higher overhead could force them to increase revenue by reducing the quality and quantity of services, an abuse difficult to detect. And should they penetrate areas where health care deficiencies are most glaring, multiphasing testing procedures would not reduce degenerative disease but could pick up much unanticipated disease to further inflate the doctor shortage. The healthy-young would pay for services they don't need and never use while costs will undoubtedly rise because of additional services required to treat diseases uncovered by screening elderly patients.

Since the transition to a system in which HMOs develop enough to determine what significant share of the health care market they might occupy, steps should be taken to solve such problems as will develop after operations get underway. Intelligent debate can avert nasty and unfortunate decisions that could move the health system in the direction of permanent and restrictive regulations. Enough questions arise to suggest that HMOs are vulnerable economically, sociologically and medically. The promise of an HMO is to lower costs by stimulating competition over prices and benefits. Preserved is the consumer's time honored right to choose a physician and the kind of health system he prefers. Dependent on federal assistance, not only for their conception but for their very survival, HMOs could become wards of the state, steadily using tax money to perpetuate the illusion of economical care. Through government's elaborate administrative process, they could drain resources needed for true health maintenance. Besides what would be their advantage over the growth of private practice through medical foundations, a growth that should be accompanied by quality of care, greater accessability and lower cost. HMOs were created to provide quality health care for those citizens least able to afford it in today's fee-for-service environment. As of now, no proof exists that federally funded HMOs could handle the assignment, or much less handle it within the financial framework envisioned by those who support this concept. One fact emerges, HMOs are a reality. They may work if we physicians care enough about the practice of medicine to experiment, to keep an open mind and place the best interests of our patients uppermost. The HMO experiment will continue until that day when its value has been proved one way or another.

C.M.C.

Hospitals and Emergency Care Planning

It is generally agreed that development of a communitywide emergency care system depends on planning. This can be carried out by emergency care councils, as suggested by Dr. Henry Huntley[1]. A key feature of the plan is to organize the emergency departments of receiving hospitals so that mobile units, the public, and the hospitals themselves know their role and responsibility. Thus, capability of an area, municipality or region is defined and a proper, organized response is expected for nearly all daily emergencies and even the infrequent disaster. This response has to maximize the efficient use of resources, be well accepted by the consumer and providers, and be well understood by everyone.

It is in the development of such a plan that hospitals and their staffs display their anxiety, usually in the form of negativism. The common term "categorization"[2] describes that activity wherein the hospital emergency departments have their capability and role in the emergency care plan defined. In the case of Ohio,[3] this was carried

out by community councils, whereas in Washington state[4] the medical society furnished the guidance.

In either case, the problem is to assess the capability of the receiving hospital to handle sudden and unexpected emergencies. This involves the emergency department, as well as ancillary services such as laboratory, radiology, intensive care, and the operating room. Time of response figures in the equation. The more critical the injury or illness, the greater demand placed on fast, as well as adequate, response. The concept of an advanced life support station (resuscitation, including definitive therapy) in nearly every hospital is under investigation.

Organization of the community's health resources is part of a comprehensive community-wide emergency medical care plan. It should be clear that the ability of the health providers (including professionals) to identify their role in this plan is the key. Many communities have completed this phase of planning, proving men of good will can overcome the obstacles, including the not inconsiderable "territorial imperative." The alternative here, as in many other areas, is to "delegate" the decision-making power to other agencies, often uninterested or indifferent to the opinion of organized medicine and health providers.

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How Is Your Blood Pressure?

JAMES E. FULGHUM, M.D., M. E. GROOVER, M.D. AND W. G. SIMPSON, M.D.

In the survey conducted in three west Florida counties among some 17,500 persons aged 14 and above, the blood pressure in 16% was found to be 150/90 and above, and 2,838 were classified as hypertensive. Only 25% were receiving adequate treatment.

Those with hypertension but not under treatment were queried and 28% replied they were unaware of the condition, 23% stated they could not afford the necessary medication, 17% could not tolerate the medication, 10% thought they had been cured, and 22% gave other explanations.

Problems encountered in the hypertension screening survey included (1) a high dropout rate due perhaps to the fact that patients saw no need for therapy since they felt all right, (2) intolerance to therapy, (3) high cost of drugs for the medically indigent, and (4) discontinuation of therapy when the blood pressure returned to a normal level.

Concern on the part of the private physician and a sensitivity to the patient's other needs are important in care and treatment. It is necessary to identify the patient as early as possible and initiate adequate and continuing treatment before irreversible damage has occurred. The patient should be made aware that high blood pressure, in most cases, is a lifetime problem, it is the major cause of stroke, modern drugs can control it, usually treatment is a daily routine, and medicine will not cure but will control the hypertension.

Conclusion

Early detection and prolonged treatment of abnormally elevated blood pressure are essential to successful management.

The public should be informed of the potential seriousness of hypertension and encouraged to have routine blood pressure checks.

Continuing treatment must be closely supervised.

The hypertensive patient, often asymptomatic, must recognize the need for continued surveillance if his condition is to be adequately controlled.

Dr. Fulghum is Chief of the Bureau of Adult Health and Chronic Diseases, Division of Health, Department of Health and Rehabilitative Services, State of Florida. Dr. Groover is Administrator of the Bureau's Cardiovascular Section and Director of the Hypertension Screening Project. Dr. Simpson is Director of the Holmes, Washington and Walton County Health Departments.

▶ Dr. Fulghum, P.O. Box 210, Jacksonville 32201.

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Contraindications: Thyrotoxicosis, acute myoc dial infarction. **Side effects:** The effects of SY THROID (sodium levothyroxine) therapy are sl in being manifested. Side effects, when they occur, are secondary to increased rates of bo metabolism; sweating, heart palpitations w or without pain, leg cramps, and weight lo Diarrhea, vomiting, and nervousness have a been observed. Myxedematous patients w heart disease have died from abrupt increas in dosage of thyroid drugs. Careful observati of the patient during the beginning of any t roid therapy will alert the physician to any t toward effects.

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☐ I will pay at conference.

Name _____

Address _____

Affiliation _____

City/State/Zip _____

Medical News

Our Sexy Senior Citizens

The first symposium ever in the nation related to skill development in the field of geriatric sexuality will be held at Morton Plant Hospital, Monday, March 18, 1974. Beginning at 9 a.m., the Marriage Council of Philadelphia, a Division of the University of Pennsylvania Medical School, will direct this symposium. Special emphasis on sexual problems after strokes will be led by Dr. Martin Leschner. This symposium will be aimed at professional and paraprofessionals who work with older people. Send registration with check for $25 to Mrs. Jacqueline Boyd, Department of Education, Morton Plant Hospital, Clearwater, Florida 33516. The course is sponsored by Morton Plant Hospital Medical Staff Educational Committee, the Stroke Service at Morton Plant hospital and the Suncoast Heart Association.

Dr. Grams Joins Florida Faculty

Ralph R. Grams, M.D., who has been serving as systems designer for the total Air Force medical information system, has joined the faculty of the University of Florida College of Medicine.

Dr. Grams will fill four roles at Florida—Associate Professor of Pathology, Director of the Division of Chemical Pathology, Chief of the Division of Systems Development and Administrative Director of the Department of Pathology Laboratory Services in the Shands Teaching Hospital.

A 1967 graduate of the University of Minnesota School of Medicine, Dr. Grams had residency training in laboratory medicine.

Course in Cardiac Emergencies

A postgraduate course entitled "Master Approach to Cardiac Emergencies" will be held at Disney World's Contemporary Hotel, May 2-4.

The course is sponsored by the University of Miami School of Medicine and the Council on Clinical Cardiology of the American Heart Association in cooperation with the Florida Heart Association. Out-of-state experts will join members of the Miami faculty in presenting the program.

Fees include $125 for Fellows and Members of the Council and physicians in training; and $150 for nonmembers of the Council. The American Academy of Family Practice has approved the program for 12 prescribed hours.

Programs and registration blanks may be obtained from: Louis Lemberg, M.D., University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

Dr. Haeck To Head ACEP

William T. Haeck, M.D., of Jacksonville, has been named President Elect of the American College of Emergency Physicians and will be installed as President in November.

Dr. Haeck, an emergency physician for the past six years, has been on the Board of the 4,600-member medical organization since 1969.

A member of the Duval County Medical Society and the Florida Medical Association, Dr. Haeck has been active in several groups involved with emergency medicine, including the FMA Committee on Emergency Medical Services.

Dr. Palmer On Federation Board

George S. Palmer, M.D., of Tallahassee, Executive Director of the Florida Board of Medical Examiners, has been elected to the Board of Directors of the Federation of State Medical Boards of the United States.

The election of Dr. Palmer to a three-year term came at the Federation's recent meeting. Dr. Palmer is a Past President of the Florida Medical Association.

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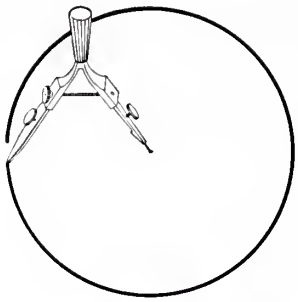

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ORGANIZATION

Tentative Scientific Program

1974 Centennial Annual Meeting

Florida Medical Association

Scientific Sections

Thursday Afternoon, May 9

Infectious Disease and Antibiotics

Chest Medicine (Nonbacterial Pneumonias and Coronary Artery Surgery)

Psychiatry

Thursday Evening, May 9

Special Program: "Sex and Sexuality"—William H. Masters, M.D. and Virginia E. Johnson, Reproductive Biology Research Foundation, St. Louis, Missouri

Friday Morning, May 10

Infectious Disease and Antibiotics (Second Section)

Internal Medicine (Therapy of Common Disorders in Internal Medicine)

Otolaryngology (Allergy and Otolaryngology)

Friday Afternoon, May 10

Pediatrics and Obstetrics/Gynecology

Arthritis (Medical and Surgical Approaches to the Treatment of Arthritis)

Family Practice (Office Proctology)

Thoracic and Cardiovascular Surgery

Emergency Medicine

Saturday Morning, May 11

Dermatology (The Pathogenesis and Treatment of Acne)

Otolaryngology (Second Section)

Pediatrics

General Surgery (Fiberoptics in Surgery)

Colon and Rectal Surgery

Ischemic Heart Disease (Current Concepts for the Practicing Physician)

Preventive Medicine (Prevention and Detection of Coronary Disease)

Physical Medicine and Rehabilitation (The Use of Orthetic Devices in Rheumatoid Arthritis Involving the Upper Extremities).

Obstetrics and Gynecology

Saturday Afternoon, May 11

Pediatric Surgery

Candid photos taken by John W. Glotfelty, M.D., Lakeland, at the Sixteenth Annual FMA Leadership Conference, Orlando, January 26-27, 1974.

(Top left to right) Frederick C. Andrews, M.D., Mt. Dora; Mrs. Arnold J. (Bennie) Spanjers, Winter Haven; Paul A. Tanner, M.D., Auburndale; Mrs. Thad Moseley, Jacksonville; W. Harold Parham, Jacksonville; Mrs. O. J. Keller, Tallahassee; Richard C. Dever, M.D., Miami; Daniel Roberts, M.D., Rockledge; Emanuel Papper, M.D., Miami; J. Gerard Converse, M.D., Winter Haven; Willard E. Manry Jr., M.D., Lake Wales; James T. Cook, M.D., Marianna; Edward G. Haskell Jr., M.D., Tallahassee; Frank C. Coleman, M.D., Tampa; Louis C. Murray, M.D., Orlando; Sanford A. Mullen, M.D., Jacksonville; Joseph C. Von Thron, M.D. Cocoa Beach; Dr. and Mrs. Karl R. Rolls, Sarasota; Dr. and Mrs. Grayson C. Snyder, Blountstown; Howard M. DuBose, M.D., Lakeland; Irving M. Essrig, M.D., Tampa; Gerold L. Schiebler, M.D., Gainesville; O. J. Keller, Tallahassee; Wilson T. Sowder, M.D., Jacksonville; Stephen Z. Schilder, M.D., Shalimar; Mrs. Edward R. Annis, Miami; Mrs. Joseph C. Von Thron, Cocoa Beach; William H. Harrison, M.D., Daytona Beach; Ray E. Murphy, M.D., Pompano Beach; Louis E. Cimino, M.D., Tampa; Dr. and Mrs. R. Benjamin Moore, West Palm Beach.

(Top left to right) Robert E. Zellner, M.D., Orlando; George H. Evans, M.D., Tallahassee; Guy T. Selander, M.D., Jacksonville; Warren M. Barrett, M.D., Jacksonville; Philip B. Phillips, M.D., Pensacola; Thad Moseley, M.D., Jacksonville; William J. Dean, M.D., St. Petersburg; O. J. Keller, Tallahassee; Joseph C. Von Thron, M.D., Cocoa Beach; Robert P. Johnson, M.D., Tallahassee; Edward R. Annis, M.D., Miami; Thad Moseley, M.D., Jacksonville; R. E. Allison, M.D., Stuart; Donald L. Weeks, M.D., Orlando; Franklin B. McKechnie, M.D., Winter Park; Edward D. Hagan, Jacksonville; Robert E. Windom, M.D., Sarasota; Norman Coulter, M.D., Orlando; Eugene L. Nixon, Jacksonville; Jack Q. Cleveland, M.D., Coral Gables; William C. Roberts, M.D., Panama City; Edward R. Annis, M.D., Miami; Joseph C. Von Thron, M.D., Cocoa Beach; Rufus K. Broadaway, M.D., Miami; Robert N. Webster, M.D., Tallahassee; William N. Ainsworth, M.D., Jacksonville; James W. Walker, M.D., Jacksonville; W. Reed Bell, M.D., Pensacola; Mrs. Howard M. DuBose, Lakeland and Mrs. John W. Glotfelty, Lakeland.

MEETINGS

Approved by FMA Committee on Continuing Education

MARCH

2 Eighteenth Annual Watson Clinic Seminar, Watson Clinic, Lakeland. For information: Gordon F. Moor, M.D., Watson Clinic, Lakeland 33802

7-10 Skin 1974: Modern Management of Common Skin Disorders—Seminars for the Family Physician
Playboy Plaza Hotel, Miami Beach*

8- 9 Allergic Diseases, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

13-15 Fifth Annual Topics in Internal Medicine Hilton Hotel, Gainesville**

13-16 Sixth Teaching Conference in Clinical Cardiology Sheraton Four Ambassadors Hotel, Miami*

13-17 Thyroid and Endocrine System Investigations With Radionuclides, Playboy Plaza Hotel, Miami Beach*

14-15 Electrodiagnosis and Management of Back, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

15-18 The Phono and the Physical, Hilton Hotel, St. Petersburg. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

18-23 Instruction Courses in Coronary Care for the Practicing Physician, University of Miami School of Medicine, Miami*

23-Apr. 2 Second Annual University of Florida Medical Seminar Cruise, S.S. Doric.**

26-30 Radiology in Medical and Surgical Emergencies. Playboy Plaza Hotel, Miami Beach*

29-30 Genetic Resultant Conditions, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

30 Eighth Annual Pinellas Seminar for Physicians, Port O'Call Resort Inn, St. Petersburg. For information: Mr. John Carbonneau, 1001 South MacDill Avenue, Tampa 33609

30 First Florida Perinatal Conference of the Florida Neonatal Intensive Care Program, "Current Concepts in Perinatology," Royal Inn, Buena Vista, Florida. For information: Richard J. Boothby, M.D., 5720 Atlantic Blvd., Jacksonville 32207.

APRIL

3- 5 "Clinical Nephrology and Heart Disease II," Eden Roc Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

8- 9 Hypertension, Sheraton Four Ambassadors Hotel, Miami*

8-12 Ophthalmic Plastic and Corneal Surgery Doral Hotel, Miami Beach*

18-22 Thirteenth Workshop in Electrocardiography for Physicians and Cardiac Nurses, Tides Hotel and Bath Club, Redington Beach. For information: Henry J. L. Marriott, M.D. St. Anthony's Hospital, St. Petersburg 33705

19-20 Practical Optics and Refraction, J. H. Miller Health Center, Gainesville**

22-27 Courses of Instruction in Coronary Care for the Practicing Physician, University of Miami School of Medicine, Miami 33152*

25-27 Urology: Selected Topics for the Practitioner, Hilton Hotel, Gainesville**

MAY

2- 4 Master Approach to Cardiac Emergencies Contemporary Hotel, Disney World, Orlando*

3- 4 The Management of the Critically Ill Patient, Hilton Hotel, Gainesville**

4 An Intensive Day in Critical Care Medicine, Hilton Hotel, Gainesville**

9-11 Clinical Care of Bone Tumors, University of Florida, Gainesville**

9-12 Microneurosurgery, Innisbrook Resort & Gulf Club, Tarpon Springs**

13-18 Instruction Courses in Coronary Care for the Practicing Physician, University of Miami School of Medicine, Miami*

17-18 Acute Coronary Care, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

19-20 Respiratory Disease Physicians Seminar, Turtle Inn, Atlantic Beach. For information: Florida Lung Association, P. O. Box 8127, Jacksonville 32211

24-26 Instrumentation in Cardiology, Port O'Call Resort, St. Petersburg. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

JUNE

17-22 Eighth Annual Workshop in Electrocardiography, Sheraton Olympic Villas, Orlando. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

AUGUST

15-17 Postgraduate Obstetric-Pediatric Seminar, Pier 66 Hotel, Fort Lauderdale. For information: A. F. Caraway, M.D., P.O. Box 210, Jacksonville 32201

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*For Information: Contact the Division of Continuing Education, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32601.

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Letters

To the Editor: The special article by Dr. Daniel Nunn in the December issue of JFMA was interesting; however, I thought it was unfortunately titled and the implied message—the ineptitude of "nationalized medicine"—was unwarranted by the facts of the article (although might well be warranted on the basis of more serious analysis).

Is it reasonable to characterize Dr. Nunn's anecdote as "An Experience With Nationalized Medicine" and imply that the kind of defects in the provision of medical care which he reported could only occur under a system of "nationalized medicine"? Reliable reports of much worse (and tragic) failure of medical care are easily obtainable in countries depending on "private" or non-nationalized medical practice systems. If Senator Kennedy submitted to you a polemic containing a testimony of horrors from someone who sought medical help in Jacksonville, would you title the piece "An Experience With Free Enterprise Medicine"? I hope not.

The problem of making available the best medical attention to all citizens at all times is something which calls for a great deal of thought. The problem is not unique to one system of health care delivery. Let us be wary of designating scapegoats—such a response tends to divert us from coming to grips with the problem we seek to solve.

John J. Benton, M.D.
Panama City

DOCTOR, MARK THESE DATES ON YOUR CALENDAR:

MAY 8-12, 1974

100TH ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION

DIPLOMAT HOTEL
HOLLYWOOD

To the Editor: The Florida and South Florida Psychiatric Societies are seeking to reinstate psychiatric coverage for the FMA member physicians and their families in Blue Cross/Blue Shield. We want you to let the membership know that we are seeking to find what would be realistic costs from the experience in other states so that premiums can be set that would permit sound financial practices. We have therefore been seeking to learn the experience of those in other states and will be presenting our findings to the proper committees in the Florida Medical Association for their consideration in planning new insurance for the membership.

We would appreciate your publishing this letter to acquaint the Association's membership with our activities.

Richard E. Gordon, M.D., Ph.D.
Chairman, FPS Insurance Committee
Gainesville

Medical Director

To administer Clinical and Environmental Health Program at the Kennedy Space Center and Patrick Air Force Base, Florida.
Pan American World Airways, Inc. under contract to NASA, has immediate need for a Board Certified or Board Eligible Physician in Occupational and Preventive Medicine to direct staff providing occupational medical services. (both prevention and treatment at Cape Kennedy)
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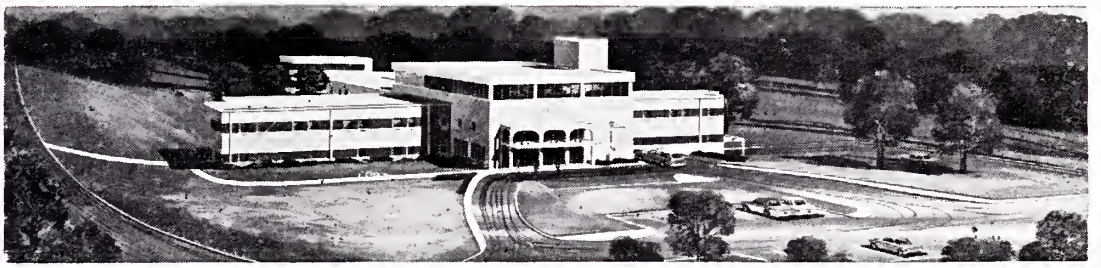

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Annual Meeting Schedule of Activities

Wednesday, May 8, 1974

10:00 a.m.-4:30 p.m. General Registration — FMA & WA/FMA — ENTRANCE, EXHIBIT HALL

12:00 -4:30 p.m. Registration—State Officers, Chairmen, County Presidents—MEZZANINE THEATRE

Pre-registration—House of Delegates—MEZZANINE THEATRE

Art Show entries accepted—EXHIBIT HALL

11.00 a.m. Executive Committee Meeting—SUITE OF PRESIDENT/PRESIDENT-ELECT

1:00 p.m. Pre-Convention Board Meeting—All State Officers, Chairmen of Standing & Program Extension Committees, County Presidents. All other members welcome as guests—MEZZANINE THEATRE

Thursday, May 9, 1974

Visit Art Show — Exhibit Hall

Awards Luncheon Today

7:30 a.m.-8:45 a.m. Complimentary Continental Breakfast—MEZZANINE THEATRE

8:00 a.m.-4:30 p.m. General Registration—FMA & WA/FMA — ENTRANCE, EXHIBIT HALL. Registration—State Officers, Chairmen, County Presidents and Delegates to House of Delegates— MEZZANINE THEATRE

Art Show Open — EXHIBIT HALL

9:00 a.m.-12 noon 1st Session, House of Delegates—MEZZANINE THEATRE. Delegates please wear identifying badges and be seated with your delegation by district by 9:00 a.m.

COUNTY MELODIES—Volusia, Seminole, Sarasota, St. Lucie-Okeechobee-Martin, St. Johns, Polk, Pinellas, Panhandle, Palm Beach, Osceola, Orange, Marion, Manatee, Lee, Lake, Hillsborough, Highlands, Escambia, Duval, Dade, Collier, Charlotte, Capital, Broward, Brevard, Bay, and Alachua.

12:15 p.m. Awards Luncheon—Café Crystal Room. Honoring Past Presidents, presentation of Art Show Awards, Peggy Wilcox Award presentation and other awards.

2:30 p.m.-5:00 p.m. 2nd Session, House of Delegates—MEZZANINE THEATRE. Delegates wearing badges should be seated with their delegations by 2:30 p.m. Memorial Service. Message from Mrs. Erle E. Wilkinson, First Vice President, Woman's Auxiliary to the American Medical Association. Installation of 1974-75 Officers: Joseph C. Von Thron, M. D., President, Florida Medical Association, Inc.

Friday, May 10, 1974

8:30 a.m.-4:30 p.m. ART SHOW OPEN—EXHIBIT HALL

9:00 a.m. Post-Convention Board Meeting—MEZZANINE THEATRE. State Chairmen and County Presidents please attend. (Be ready to transfer files to new board)

12:15 p.m. Auxiliary FLAMPAC Luncheon—Café Crystal Room. Guest Speaker: Mrs. Marilyn Van DerBur Atler (former Miss America)

Eighth Annual Benefit Art Show

Exhibit Rules and Regulations

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.).
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of $10.00 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than May 1, 1974.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel, between 1:00 p.m. and 3:00 p.m. Wednesday, May 8. Shipped entries will be refused.
8. All entries must remain on exhibition until 3:00 p.m. on Saturday, May 11 and must be picked up between 3:00 p.m. and 4:00 p.m. Saturday, May 11.
9. Doctors, their wives and children are eligible to enter. Entry fees will be donations to the St. Augustine Medical Museum.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $_____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

( ) A Painting. Include any media in color: acrylic, oil, casein, collage, water color, pastel, etc. Size:_____ x _____. To be hung on wall.

( ) B Graphics, Include pen and ink, charcoal, photography, etc. Size:_____ x _____.

( ) C Crafts. Include pottery, ceramic, mosaic, weaving, jewelry, etc.

( ) D Sculpture

( ) I am the son/daughter of a Florida physician. Age _____.

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award" will be given and the winning entry will be used on the cover of a future issue of the FMA Journal.

A registration fee of $10.00 will be charged for each entry. Make checks payable to:

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IMPORTANT—IT IS MOST IMPORTANT TO KNOW THE SIZE OF YOUR ART OBJECTS, PAINTINGS, ETC. TO ENABLE US TO DISPLAY THEM MORE PROFESSIONALLY.

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REGISTRATION DEADLINE MAY 1, 1974

Political Action

In 1908, a professor of political science wrote a book on *The Process of Government*. Professor Bentley noted an increase in the formation of groups which were advancing their interests through government. He said that groups of people with a shared interest were putting pressure on the government and were becoming an integral part of the political scene. Little attention was paid to this man at the time, but since then his words have shown great wisdom. People with a common denominator, working together, can put pressure on the government and enact legislation favorable to their causes.

Initially, the AMA formed to "improve itself." Doctors were interested mainly in the quality of their members, medical education, licensure, and sound medical ethics; however, as we well know, government came creeping into the lives of the profession and this was brought about by other pressure groups such as the labor unions. The AMA set up headquarters in Washington and our own FMA has offices in our state capital, Tallahassee. These offices are well staffed, have good legal counsel that oftentimes drafts bills, and our lobbyists help legislators make our presence felt in Washington and Tallahassee. Now, when a pressure group becomes aware of a need in society, asks the government to do something about the need, it then becomes a political interest group, or what we know best as a Political Action Committee.

With some doctors and their wives the words AMPAC and FLAMPAC are the sour notes in our "Sound of Music." It must be because they do not understand the PAC movement. First of all, it is essential that we disassociate ourselves from the political party of our choice if, as a group, we are going to elect candidates who will listen to medicine and help achieve the goals of the profession. Singly, as doctors and wives who are Republicans or Democrats, we cannot hope to achieve anything for the profession. Naturally, we have differences of opinion regarding candidates and issues. These are taken into consideration, a consensus is reached, and that which is best for the entire group is then advanced. At times, candidates not of our choice will be supported with PAC funds, but as individuals we must realize that through the process of candidate evaluation, the man who will do the most for medicine is the one supported with PAC funds, whether he is Democrat, Republican, or Independent. The PAC movement involves more than contributing to candidates. Education plays an important part in orientation on issues, candidates, and parties.

Labor is highly organized. Their members are automatically assessed for their political action. Business is also organized to protect its interests. So, too, must medicine be politically interested and the way you can really show this interest is by joining the PAC. *Please*, let me make it clear, that *you* as a member are needed in the movement. Most wives assume that their husband's membership automatically makes them members; this assumption is incorrect. Regular membership is $25, and if you want to prove your sincerity, become a Sustaining Member for $100.

Mrs. Samuel L. Renfroe (Marge)
WA Representative to FLAMPAC Board
Ocala

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Miscellaneous

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situations wanted

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ALLERGIST—Chest physician, age 43, certified allergy. Academic position university-affiliated hospital; head, chest and allergy sections. Experienced chest disease, pulmonary function lab, tuberculosis, RICU, etc. Desires association with established practice, group or consider progressive hospital lab. Inquiries: John McCloskey, M.D., 2380 Packard Ave., Huntingdon Valley, Pa. 19006.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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This psychoneurotic often responds

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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APRIL COVER (Top left) Guest speakers, William H. Masters, M.D.; Mrs. Virginia Johnson (Famous Masters and Johnson team); Gov. Otis R. Bowen, M.D., of Indiana; J. R. Schenken, M.D., Omaha, Neb.; Joseph C. Von Thron, M.D., FMA President. (Top right) Marilyn Van Derbur Atler, former Miss America; Sammy Kaye, orchestra leader; Mary Ann Mathews, WA/FMA President; William M. Straight, M.D., FMA Historian and Thad Moseley, M.D., FMA President-Elect. Credit for cover design and art work goes to Mary Kay Samorisky, secretary, FMA Communications Department.

President's Page

Harold Parham - 25 Years - FMA

All editorials are difficult, but this one presents an unusual challenge. How can 25 years of outstanding contributions to the Florida Medical Association by its executive vice president be adequately acknowledged in this small space?

While I have admired all of the FMA past presidents whom I have known, it has been only recently that I have fully appreciated the role played by Harold Parham. This man magnifies the image of the president without ever detracting from the honor bestowed upon the president by his colleagues in Florida medicine. He emphasizes the strengths of the president, while filling the void created by any weaknesses. He quietly, yet capably, provides the continuity and stability required for the ongoing work of the FMA.

Each day I have become more impressed by Harold's executive capabilities—and more astounded by his mental capacity. His mind is a steel trap for the fellow who challenges the outcome of a legislative action 20 years ago—and a steel vault containing the reason a president was late for a board meeting 16 years ago. I know of no encyclopedia or computerized memory bank which rivals his wealth of information relative to organized medicine.

They say that the real measure of a man's success must be in the judgment of his peers. Here, again, Harold has risen to the top. The American Association of Medical Society Executives, in recognition of his many attributes, elected him as their national president in 1969.

It would be impossible for me to express the thoughts of the many past presidents who have worked with Harold on the way to his silver anniversary with the FMA. He has thought and acted like a doctor for so many years that, for our purpose, he is one. Future presidents, beginning with Thad Moseley, will soon learn how lucky they are. For 365 days, each of them will fare better than Robinson Crusoe—because Friday couldn't hold a candle to Harold Parham.

In conclusion, no tribute to Harold should overlook the fact that his personable wife, Mary, has complemented his efforts through the years. The doctors of Florida recognize and appreciate the extra pluses which she has provided.

Harold, I speak for Bill Dean, Jim Cook, William M. Rowlett, Edward Jelks, Walter Jones, Joe Stewart, Robert McIver, F. K. Herpel, Duncan McEwan, Bill Roberts, Jere Annis, Ralph Jack, Leo Wachtel, Bob Zellner, Warren Quillian, Sam Day, Phil Hampton, George Palmer, Dean Steward, Jack Cleveland, Henry Babers, Floyd Hurt and myself as I attempt to express our gratitude to you. Thanks for being the guy you are.

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Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®

BRAND OF **CONJUGATED ESTROGENS TABLETS, U.S.P.**

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

Ayerst.

AYERST LABORATORIES
New York, N.Y. 10017

Dean's Page

Volume 1

Donn L. Smith, M.D.

As a fortunate possessor of Volume I of the *Journal of the AMA,* one finds it enjoyable and informative to read and marvel occasionally at American medicine circa July, 1883. Browsing through the volume, one is simultaneously struck and moved by the enormous changes in medical practice that have occurred since 1883, and the surprising lack of change in the political and ethical issues of 1883 vs. 1974.

Some interesting examples of change are illustrated by various papers and their titles. In September of 1883, fourteen new cases of yellow fever were reported at the Pensacola Navy Yard and a detailed history of the epidemic is chronicled in *The Journal.* A few pages along is a beautiful and classic paper by Austin Flint entitled "On Early Tapping in Cases of Ascites." Although there have been some technical changes during subsequent years, this particular paper presents a superb model of medical communication. Those who would achieve excellence in writing scientific papers might well examine the writings of Dr. Flint which are characterized by concise lucidity and a creative style.

The early adventures in gastrointestinal surgery are well illustrated in an interesting paper in September, 1883 by a Dr. W. M. Fuqua. Two cases of surgical intervention in intestinal obstruction are described with disastrous results detailed, obviously the order of the day, which provide a clear and happy example of progress as one considers modern management of such cases. In tune with today's lament of the pediatrician that they work in a therapeutic desert with few remedies designed and packaged for pediatric use is a paper by Dr. Cosebier in which the problems of pediatric dosage and therapeutics are discussed. He concludes that children should be treated as human beings and that proportionate dosage be employed in types of treatment similar to those rendered to their parents. In the September 29 issue, the American Gynecological Society reported on a number of papers presented at their meeting. Included was a vigorous discussion of the merits and demerits of Dr. Lister's contributions, the conclusion being reached that cleanliness is indeed next to godliness. An interesting paper dealt with the question "Is Extirpation of the Cancerous Uterus a Justificable Operation?" The discussants were sharply divided pro and con.

Also, in Volume I is an excellent dissertation entitled "The Scientific Duties of Members of Medical Societies" by a Dr. H. B. Hemenway, which is totally appropriate for publication today. The problems of keeping abreast of science were apparently of as great concern then as today.

In a letter from Boston the practice of young physicians opening dispensaries for "free" medical treatment was deplored. The faculty of medicine at Harvard was said to have at length curbed the abuse of the clinical privileges by faculty members. Derivations of these themes are still with us, in the form of HMO's health insurance and faculty practice plans.

Last, but not least interesting, is a lengthy clinical discussion on Glycosuria from the Chicago Medical Society. In terms of what is known and practiced today, this paper reads like science fiction, illustrating the continuing human trait of being scientific and very knowledgable concerning matters about which no one really knows anything.

All in all, perusal of century old organizational documents such as the *Journal of the AMA* is a fascinating, even if essentially nonproductive, exercise in simple entertainment. I would note in conclusion that in Volume I of the JAMA almost every week letters and discussions of the National Code of Ethics appear which had its origin shortly prior to the first publication of JAMA. It is encouraging and instructive to perceive that 90 years later the profession remains seriously concerned with ethics and self-evalaution, i.e., the current PSRO debates.

Perhaps, if in many ways, the world of medicine is no better at least it is no worse, with the added asset of great technical progress as a positive and easily visible fact.

▶ Dr. Smith, University of South Florida, Tampa 33620.

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol® SODIUM
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

McNEIL
McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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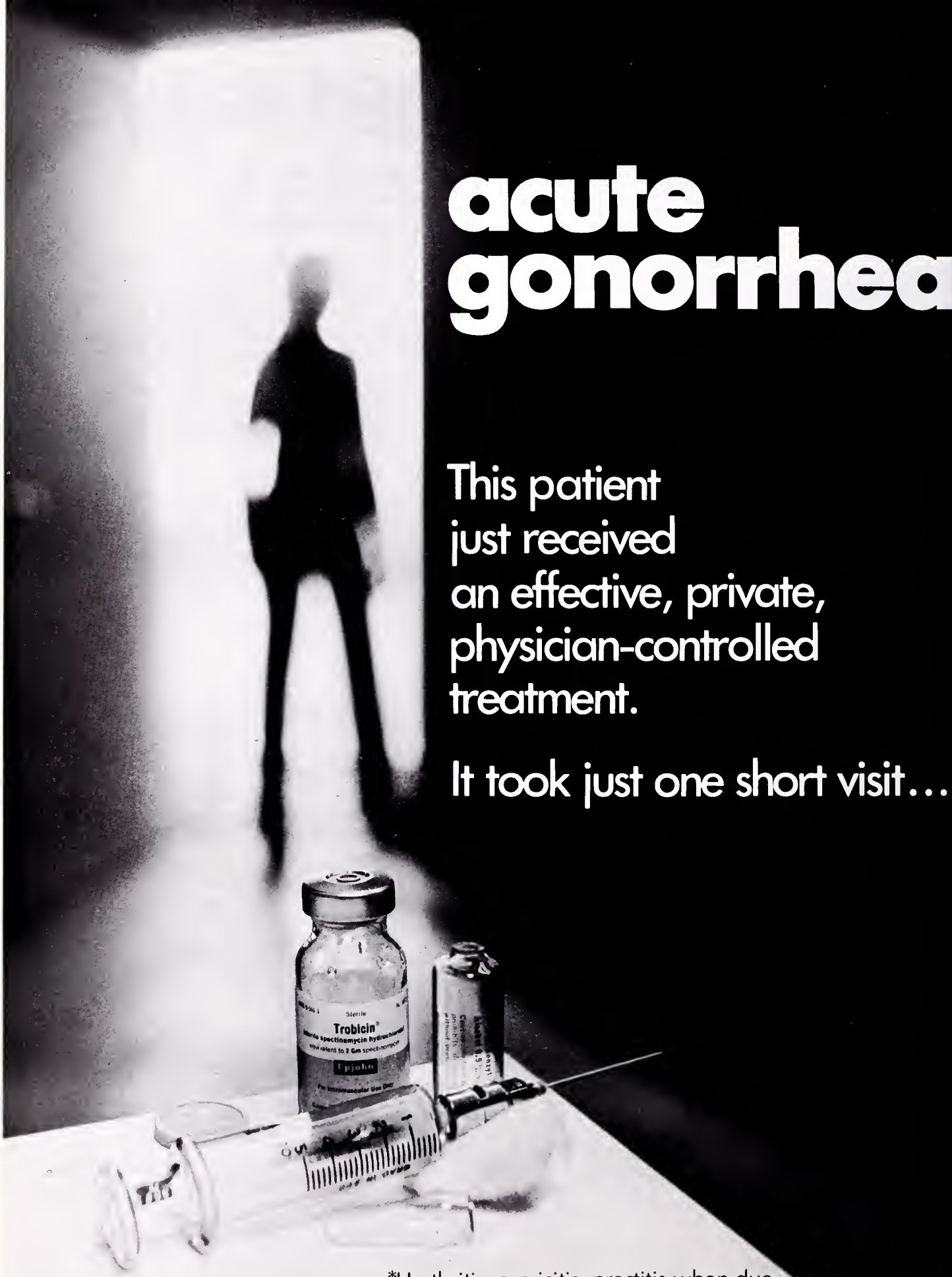
acute gonorrhea

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit...



*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

1973 The Upjohn Company J-3437-6

Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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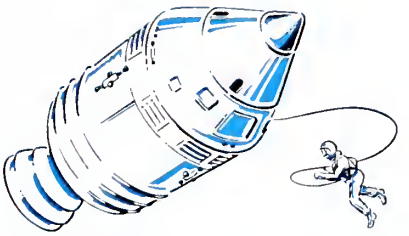


Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

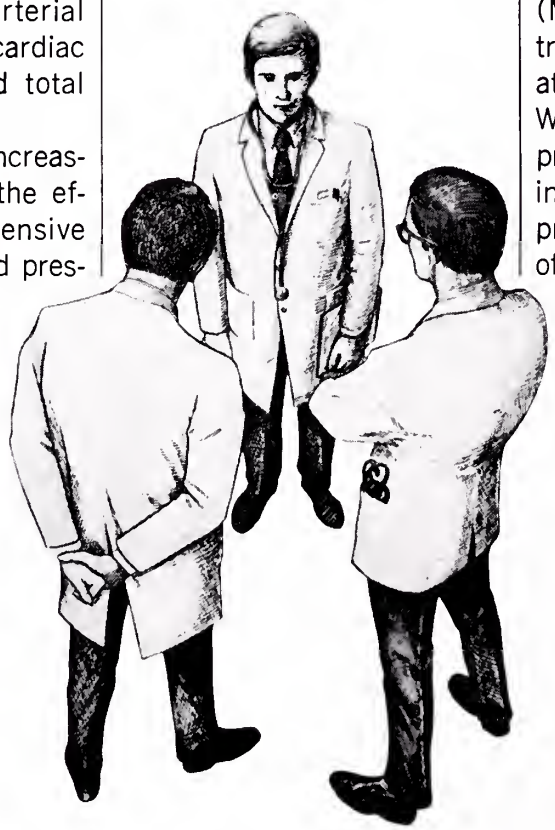
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

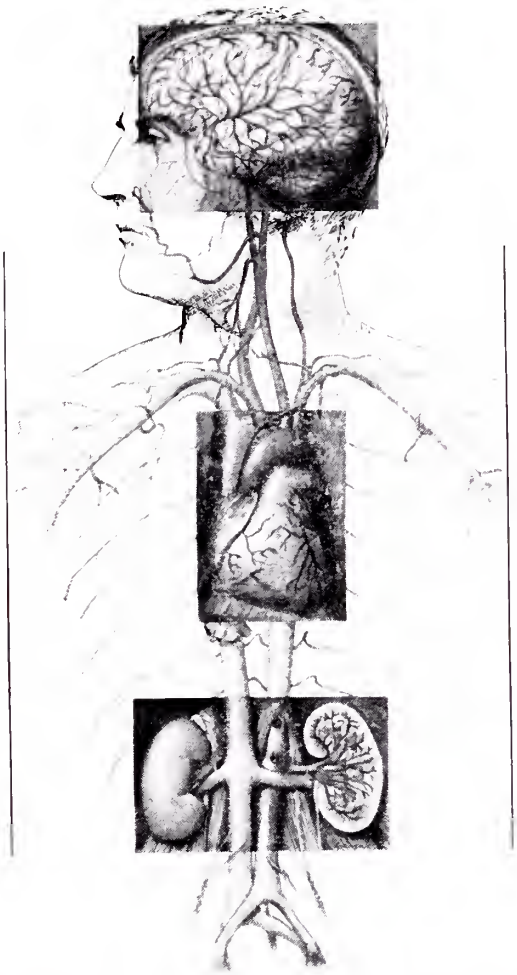
With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive

lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.



Some patients on continuous methyldopa therapy may develop a positive direct Coombs test. For more details, see the brief summary of prescribing information.

Contraindicated in active hepatic disease and known sensitivity to the drug. Not recommended in pheochromocytoma or pregnancy. It should be used with caution in patients with a history of liver disease or dysfunction. Discontinue the drug if fever, abnormal liver function, jaundice, or acquired hemolytic anemia occurs.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET®
(METHYLDOPA | MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: Acquired hemolytic anemia has occurred rarely in association with therapy with methyldopa. Should clinical symptoms indicate the possibility of anemia, hemoglobin and/or hematocrit determinations should be performed. If anemia is present, appropriate laboratory studies should be done to determine if hemolysis is present. Evidence of hemolytic anemia is an indication for discontinuation of the drug. Discontinuation of methyldopa alone or the initiation of adrenocortical steroids usually results in a prompt remission of the anemia. Rarely, however, fatalities have occurred.

Some patients on continued therapy with methyldopa develop a positive direct Coombs test; incidence reported has averaged between 10% and 20%. It rarely occurs in first six months of therapy, and if not seen within twelve months, is unlikely to develop with continued administration. Positive Coombs test is dose-related; lowest incidence occurs in patients on 1 g methyldopa or less per day. Reversal of the positive Coombs test occurs within weeks to months after discontinuation of methyldopa. Prior knowledge of a positive Coombs reaction aids in evaluation of cross match for transfusions. Patients with positive Coombs tests at time of cross match may exhibit incompatible minor cross match. When this occurs, an indirect Coombs test should be performed. If negative, transfusion with blood otherwise compatible in the major cross match may be carried out. If positive, advisability of transfusion with blood compatible in major cross match should be determined by hematologist or expert in transfusion problems.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rare cases of fatal hepatic necrosis have been reported. Liver biopsy in several patients with liver dysfunction has shown microscopic focal necrosis compatible with drug hypersensitivity. Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen; reversible agranulocytosis has been reported. Methyldopa may interfere with measurement of creatinine by alkaline picrate method and of uric acid by phosphotungstate method. When used with other antihypertensive drugs, potentiation of antihypertensive action may occur.

Usage in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Perform periodic hepatic function tests and white cell and differential blood counts during first six to twelve weeks of therapy or in unexplained fever. Discontinue if fever, abnormalities in liver function tests, or jaundice appears. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Discontinue drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Anesthetics requirements may be reduced; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension may occur after dialysis because methyldopa is removed by this procedure.

Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Do not exceed recommended daily dose of 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure, including dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency, are seen occasionally. Angina pectoris may be aggravated. Symptoms of orthostatic and exercise hypotension may occur; if symptoms occur, reduce dosage. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distension, constipation, flatus, and diarrhea occur occasionally; these can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently; if edema progresses or signs of pulmonary congestion appear, discontinue drug. Rarely, urine exposed to air may darken due to breakdown of methyldopa or its metabolites. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression, reversible thrombocytopenia, drug-related fever and abnormal liver function studies with jaundice and hepatocellular damage (see **Warnings** and **Precautions**), rise in BUN, and a single case of bilateral Bell's palsy.

Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
MERCK SHARP & DOHME

ADDENDUM

Let's make blood pressure "required reading" for all physicians.

With recent estimates that about 23 million Americans have high blood pressure—and that half of them are not even aware of it—detection of the problem in asymptomatic persons has become an issue of national importance.

Family physicians are being urged to take blood pressure readings as a matter of office routine, regardless of the presenting complaint or the reason for the visit. And because many people do not see a family physician for relatively long periods of time, some experts are suggesting that ophthalmologists, gynecologists, dermatologists, orthopedists, psychiatrists, dentists, school nurses, family planning counselors, and other health-care personnel make blood pressure reading a routine part of every examination or consultation.

Of course, a diagnosis of hypertension cannot be made on the basis of a single reading, but routine blood pressure readings can uncover potential trouble in a certain proportion of patients. And when trouble is suggested, further evaluation can be pursued more effectively.

Blood pressure—"required reading" for all physicians.

Think Inc.

To incorporate or not to incorporate? Maybe that's not the real question.

After all, you've probably heard it's a nice opportunity. That is, you can take advantage of the liberal tax treatment available to corporations through qualified pension or profit sharing plans.

So perhaps the more significant question is where to go for assistance. Perhaps you should go right to the top.

To New England Life, the company that has sold more individual policy pension trust plans than any other insurer.

In fact, we were helping physicians solve complex financial problems long before the professional corporation came along. And our agents' experience in this field, together with their reputation among physicians (as well as their lawyers and tax counselors), is a matter of record. Furthermore, the plans they can offer you and your professional advisers are preapproved by the IRS and afford the kind of flexibility necessary to develop a program to meet your needs exactly.

For instance, you have freedom in determining plan contributions or benefit levels.

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Medical News

Family Practice Examination

The American Board of Family Practice will conduct its next certification examination on October 19-20, 1974, in five centers throughout the United States.

Physicians wishing to take the examination must apply no later than June 15, 1974.

Information may be obtained from: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Three Pediatricians Honored

Three veteran pediatricians associated with the University of Florida College of Medicine received surprise honors for their contributions to the health care of children and to medical education recently.

One of those honored by the College's Department of Pediatrics was A. Ashley Weech, M.D., 79-year-old retired Chairman of Pediatrics at the University of Cincinnati College of Medicine, who now resides in Gainesville, and for several months has served as a visiting professor in pediatrics at Florida.

Dr. Weech is said to be the first physician to administer an antibiotic to a patient in this country, when he prescribed a sulfonamide for a 10-year-old girl in 1935.

The other pediatricians honored were the husband and wife team of Drs. Hugh and Cornelia Carithers, who are in practice in Jacksonville. The Carithers, both members of the clinical faculty at Florida, were honored for their contributions to the profession of pediatrics and to the children of Florida, including the establishment 10 years ago of the Hugh and Cornelia Carithers Award to be made annually to the outstanding medical school graduating senior who has excelled in child health and human development.

New Chairman at Miami

Duncan A. Holaday, M.D., has been appointed Professor and Acting Chairman of the Department of Anesthesiology, University of Miami School of Medicine, effective February 1, 1974.

A member of the Dade County Medical Association and FMA, Dr. Holaday succeeds Frank Moya, M.D., who is now located at Mt. Sinai Medical Center, Miami Beach.

Rheumatic Fever Group Meets

The newly-created Task Force on Rheumatic Fever met recently in Tampa and adopted several recommendations.

Among proposals approved were those calling for changes in the drug order form so that the physician would be relieved of responsibility for determining the patient's financial status; and for physicians to report cases of rheumatic fever to the Florida Division of Health.

The Task Force is composed of representatives of the Florida Divisions of Health and Children's Medical Services, the Florida Medical Association, the Florida Heart Association and the Florida Pediatric Society.

Medical Alert Program

Argonaut Insurance Co., which underwrites the FMA-sponsored professional liability insurance program, has inaugurated a new information program called Medical Alert Communications.

The Company is to mail to each of its policyholders a large binder which it hopes they will keep in their offices for filing bulletins as they are received.

The project is designed to assist the health care industry in providing safer patient care. The bulletin series will be divided into sections dealing with medicine, nursing, hospital administration, technology, medical jurisprudence, general comment, and MAC Alerts, which are high-priority bulletins warning of potential hazards in medical treatment, drugs or instrumentation.

NCI Grant

The National Cancer Institute has awarded a three-year grant of $276,106 to establish a prostate cancer tissue collection center at the University of Miami School of Medicine.

Theodore I. Malinin, Professor of Surgery and Pathology, heads the program, which began on December 1 and will last until November 30, 1976. The program is part of a nationwide program to stimulate the search for the cause and cure of prostate cancer.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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Methaqualone Abuse Patterns, Diversion Paths and Adverse Reactions

JAMES A. INCIARDI, PH.D., DAVID M. PETERSEN, PH.D., AND CARL D. CHAMBERS, PH.D.

ABSTRACT: The history and clinical experiences with methaqualone are reviewed, and the drug careers of a cohort of methaqualone abusers are examined. Methaqualone has become the most recent "fad" drug of abuse, and it is typically used as an intoxicant, either alone or in combination with alcohol. Legally manufactured methaqualone is currently being diverted from licit drug channels through thefts from storage facilities, employee pilferage, unauthorized sales, and excessive prescribing and dispensing. Counterfeit methaqualone has also been reported. The number of chemical casualties resulting from methaqualone abuse have become significant, and these will continue to increase for as long as borderline practices exist in the drug's manufacture, distribution, prescribing and dispensing.

Methaqualone is a nonbarbiturate sedative/hypnotic drug having no distinct advantages over barbiturates and other similarly acting agents except for patients who might be allergic to or cannot tolerate the other drugs. The development of methaqualone was spirited by the recent revolution in the technology of drugs which began more than two decades ago,[1] and the drug was initially synthesized in 1951 as a possible antimalarial agent.[2,3] The hypnotic properties were determined in a series of studies undertaken in India some years later,[4,5] and since 1959 it has received widespread clinical application for sedation and hypnosis at an international level.

Methaqualone was introduced commercially in the United States in 1965, and since that time production and use have increased in geometric proportions. The volume of 300 mg dosage units distributed has expanded, for example, from some 8 million in 1968 to 114 million in 1972, while the distribution of 400 mg dosage units multiplied during the 1970-72 period from 2 million to 33 million.[6] Such increases were largely due to the promotion of methaqualone as an alternative to barbiturates—that it was clinically efficacious for daytime sedation and nighttime sleep unaccompanied by the harmful side effects and abuse potential characteristic of barbiturate drugs.

Clinical and Laboratory Experience

A wide range of clinical and laboratory experience with methaqualone has appeared throughout the literature and previous reports from more than 15 countries have discussed the drug at length in terms of clinical evidence of efficacy,[7-15] physiological and psychological dependence potentials,[14, 16-20] overdose and poisoning,[12, 18, 21-26] cross-tolerance factors,[14] REM affectation,[19-20, 27-28] effects on motor skills,[29] absorption, fate and excretion,[30-35] antitussive effects,[7,36-37] contraindications,[38] and drug interactions.[13,39,40]

From the Division of Addiction Sciences, Department of Psychiatry, University of Miami School of Medicine, Miami.

In brief, methaqualone produces sedative and hypnotic effects similar to those of the barbiturates, depressing the central nervous system. The hypnotic activity of the drug is increased by barbiturates, alcohol, and other central nervous system depressants. With a normal therapeutic dose (150-300 mg) sleep usually occurs within 10-30 minutes and lasts 6-8 hours. The general side effects can include restlessness, headache, drowsiness, dizziness, loss of appetite, nausea and vomiting, diarrhea, fatigue, dry mouth, sweating, rapid heart beat, and skin rash. Signs of mild intoxication include incoordination, slurred speech, nystagmus, increased heart rate, and drowsiness. Acute toxicity can occur from a dosage of 8 to 22 grams (when taken alone), and from lower dose levels when the drug is taken in conjunction with alcohol or other central nervous system depressants. The symptoms of acute toxicity include motor excitation, muscle spasms, overstretching of extremities, convulsions, vomiting, variations in pupil size, and coma. Death from methaqualone results from depression of the central nervous system, accompanied by shock and respiratory arrest. The lethal concentration in blood is 1-4 mg/100ml.

Patterns of Abuse

For more than a decade, the addiction potential and abuse liability of methaqualone have been noted in Britain, Japan, Germany, Argentina, Australia, and Norway.[14, 21-22, 41-45] However, the widespread acknowledgment of the hazardous nature of the drug has only been recent in the United States, primarily in popular and underground chronicles,[46-53] with less frequent commentary in the major medical literature.[20,54-55] The abuse of methaqualone was first noted on the west coast of this country during the fall of 1968,[55] and on the east coast early the following year.[56] In both circumstances, however, its popularity was inconspicuous and short-lived, perhaps resulting from the limited production of methaqualone during those years combined with the common acceptance of barbiturates as drugs of preference among sedative abusers. The dramatic increase in the prevalence and incidence of methaqualone emerged in isolated locations some 24 months ago and became established as a national pattern by the close of 1972. During the late summer of 1971, methaqualone was described to the authors as the most widely sought drug among the large population of soft drug users located in the Coconut Grove section of Dade County, Florida. During the ensuing months similar commentary was offered by reporters along both coasts and in the nation's larger cities. By mid-1972, the diffusion path of methaqualone abuse could be traced throughout alternative sections of the country. Within the state of Michigan, for example, the drug seemingly became available in large quantities initially within the heroin using subcultures of Detroit during the early fall of 1971; the same phenomenon then appeared midway across the state, in Lansing, by the spring of 1972, and on the west side, in Grand Rapids, during the summer of the same year.[56]

TABLE 1.—DEMOGRAPHIC CHARACTERISTICS OF 22 METHAQUALONE ABUSERS.

Age (Years)	Race (Sex)	Education (Years)	Primary Occupation	Arrest History
21	White (M)	11	Tree Surgeon	Yes
24	White (M)	8	Plasterer	—
21	White (F)	12	Model	—
22	White (M)	14	Musician	Yes
23	White (F)	12	Salesgirl	Yes
27	White (M)	14	Electrician	Yes
30	White (M)	14	Salesman	—
21	White (M)	11	Painter	Yes
24	White (M)	12	Trucker	Yes
22	White (M)	10	Musician	Yes
19	White (M)	12	Laborer	Yes
24	White (M)	14	Musician	Yes
26	White (M)	14	Electrician	Yes
39	White (M)	11	Waiter	Yes
21	White (F)	14	Secretary	Yes
26	White (M)	16	Salesman	—
22	White (M)	9	Tanner	Yes
18	White (F)	10	Cashier	Yes
16	White (M)	10	Student	Yes
17	White (M)	9	Waiter	Yes
25	White (F)	10	Beautician	Yes
16	White (F)	8	Student	Yes

Methaqualone is typically used as an intoxicant with dosages of 1 to 5 grams, or in lesser amounts when combined with wine or hard liquor. Such dose levels generally produce a sense of well-being, increased pain threshold, mild to severe incoordination, and a numbness of the fingers, lips and tongue.

In an effort to gain further insight as to the structure and process of methaqualone abuse, the nature and extent of such abuse was examined among 22 admitted users of the drug. All of the subjects were drawn from the Miami area, and interviewing was undertaken during the latter part of 1972. As indicated in Table 1, all of these methaqualone abusers were white, and the majority were males (73%). They were essentially adolescents and young adults in that almost three fourths were under age 25 and the median age of the total group was 22 years. Half had completed their secondary education with seven having had some college experience, and they reflected a wide variety of occupational levels. Finally, some 18 of the 22 abusers had known arrest histories; each of these users having been arrested on the average of three occasions.

The 22 methaqualone abusers began their careers in the illicit use of drugs at a median age of 15 years, and all but one had been initiated into drug abuse during their adolescent years (Table 2). Marijuana was typically the first drug abuse for most (64%) while heroin represented the onset drug for only two cases. Their first involvement with a narcotic drug occurred at a median age of 16 years, and the first narcotic was usually heroin. All of these abusers, furthermore, had had experiences with a wide variety of drugs, including opiates, sedatives, tranquilizers, antidepressants, alcohol, marijuana, stimulants, psychotogens and inhalants (Table 3).

Data descriptive of the initial involvement with methaqualone on the part of these abusers suggest that this drug-taking phenomenon existed for some time prior to the accepted date of the drug's primal emergence within the worlds of drug use. Reports have indicated, for example, that the widespread misuse of methaqualone typically began during mid-1971, followed by an abuse pattern of "epidemic" proportions the following year. Yet in counterpoint, almost two thirds of the drug users studied here had become involved with methaqualone prior to 1971 (Table 4). One abuser, a white male 26 years of age, reported a seven year history of such drug-taking. His first experiences with the drug, however, were limited to supplies of foreign manufacture, brought into the United States through Canada. Domestic varieties of methaqualone had not become readily available to him until 1969. Four additional subjects in this study commented on the availability of methaqualone of local manufacture during 1969, and all of these early abusers agreed that the late-1960's marked the onset of the drug's popularity among sedative/hypnotic abusers along the east coast.

TABLE 2.—DRUG ABUSE ONSET PATTERNS OF 22 METHAQUALONE ABUSERS.

Age (Sex)	First Drug of Abuse	Age of First Abuse	First Narcotic of Abuse	Age of First Narcotic Abuse
21 (M)	Marijuana	13	Heroin	17
24 (M)	Marijuana	16	Heroin	20
21 (F)	Desoxyn®	9	Heroin	15
22 (M)	Marijuana	16	Heroin	18
23 (F)	Marijuana	17	Heroin	18
27 (M)	Dexedrine®	18	Opium	20
30 (M)	Demerol®	21	Demerol®	21
21 (M)	Marijuana	16	Heroin	16
24 (M)	Heroin	15	Heroin	15
22 (M)	Marijuana	15	Opium	17
19 (M)	Marijuana	16	Heroin	16
24 (M)	Marijuana	15	Heroin	19
26 (M)	Amyl Nitrate	15	Heroin	16
39 (M)	Heroin	17	Heroin	17
21 (F)	Marijuana	12	Paregoric	13
26 (M)	Dexedrine®	12	Heroin	16
22 (M)	Dexedrine®	12	Opium	16
18 (F)	Marijuana	12	Demerol®	14
16 (M)	Marijuana	12	Heroin	15
17 (M)	Marijuana	12	Heroin	15
25 (F)	Marijuana	11	Heroin	12
16 (F)	Marijuana	13	Opium	14

Table 3.—Drugs Abused by 22 Methaqualone Abusers.

Age (Sex)	Opiates	Sedatives	Tran-quilizers	Anti-depres-sants	Alcohol	Mari-juana	Stimul-ants	Psycho-togens	Inhal-ants
21 (M)	Yes	Yes	—	—	Yes	Yes	Yes	Yes	Yes
24 (M)	Yes	Yes	—	—	Yes	Yes	Yes	Yes	—
21 (F)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
22 (M)	Yes	Yes	Yes	—	—	Yes	Yes	Yes	—
23 (F)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	—
27 (M)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
30 (M)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes
21 (M)	Yes	Yes	—	—	Yes	Yes	Yes	Yes	Yes
24 (M)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
22 (M)	Yes	Yes	Yes	—	—	Yes	Yes	Yes	—
19 (M)	Yes	Yes	—	—	Yes	Yes	Yes	Yes	—
24 (M)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	—
26 (M)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	—
39 (M)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes
21 (F)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes
26 (M)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes
22 (M)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes
18 (F)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	—
16 (M)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes
17 (M)	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes
25 (F)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16 (F)	Yes	Yes	—	—	Yes	Yes	Yes	Yes	Yes

Table 4.—Patterns of Methaqualone Abuse of 22 Methaqualone Abusers.

Age (Sex)	Age of First Methaqualone Abuse	Year of First Abuse	Total Years of Abuse	Addicted to Methaqualone	Treatment for Methaqualone Abuse
21 (M)	18	1970	2	—	—
24 (M)	22	1971	1	—	—
21 (F)	18	1970	3	—	Yes
22 (M)	18	1969	2	—	—
23 (F)	19	1969	2	—	—
27 (M)	25	1971	2	Yes	Yes
30 (M)	28	1971	1	—	—
21 (M)	18	1970	2	—	—
24 (M)	22	1971	1	Yes	—
22 (M)	20	1971	1	—	—
19 (M)	16	1970	2	—	—
24 (M)	22	1971	1	—	—
26 (M)	19	1965	7	—	—
39 (M)	36	1970	2	—	—
21 (F)	17	1969	3	—	—
26 (M)	20	1967	2	Yes	—
22 (M)	19	1970	2	Yes	—
18 (F)	15	1970	1	—	—
16 (M)	15	1972	1	—	—
17 (M)	14	1970	2	—	—
25 (F)	20	1968	5	—	—
16 (F)	14	1971	2	—	—

Table 5.—Acute Fatal Reactions to Methaqualone, Jackson Memorial Hospital.

Age (Years)	Race (Sex)	Other Agents Found in Urine at Autopsy
Accidental Overdoses:		
18	White (F)	Alcohol
18	White (M)	Methadone
17	White (M)	Methadone
21	White (M)	Unidentified Opiate
18	White (M)	Ethchlorvynol
Suicidal Gestures:		
70	White (M)	Alcohol
51	White (F)	None
70	White (M)	Alcohol
23	White (M)	None

Only four of the methaqualone abusers reported on here were ever addicted to the drug (Table 4). Most (59%) defined methaqualone as their sedative of preference, but using the drug only as a supplement to their varying patterns of primary abuse. The remaining five subjects used the drug on a sporadic basis, in limited quantities stretched over a period of 1-2 years.

Diversion

Legally manufactured and distributed methaqualone is currently being diverted from licit drug channels through a variety of mechanisms—thefts from storage facilities, employee pilferage, unauthorized sales, and excessive prescribing and dispensing.[6, 57] Commentary offered by the 22 methaqualone abusers described here combined with data collected incidental to this study suggest that a large portion of the methaqualone being diverted for nonmedical use is obtained as a result of physician over-prescribing, pharmacists over-filling prescriptions, and inadequate internal controls over institutional drug supplies. In addition, many of these abusers indicated that their sources of supply included street dealers who specialized in the distribution and sale of methaqualone. One such dealer reported to the authors that he purchased methaqualone in wholesale quantities from a pharmacist who regularly maintained large supplies of the drug. This dealer typically sold individual 300 mg tablets at prices ranging from .50-$1, and as low as .20 in quantities of 1,000 or more.[56]

Methaqualone has also been clandestinely manufactured. Counterfeit methaqualone of 300 mg potency has been gathered and analyzed in the Miami area;[56] users, however, generally express a preference for the genuine pharmaceutical product.

Adverse Reactions

Emergency Room and Medical Examiner reports from Jackson Memorial Hospital (Dade County, Florida) indicated a total of 101 acute nonfatal reactions to methaqualone during 1972. The race/sex distribution of these cases reflected an almost equal division by sex (47.5% male, 52.5% female), with an over-concentration among whites (82.2%white, 17.8% black.). The age distribution was disproportionately large among the young with some three fourths of the cases under age 25. Among these 101 methaqualone reactions, another substance, including alcohol, was associated with 46 (45.5%) cases. More specifically, 54.5% of the acute reactions were to methaqualone only, 31.7% involved methaqualone plus another drug (excluding alcohol), 8.9% involved methaqualone plus alcohol, and 4.9% involved methaqualone plus alcohol and another drug. At least two thirds of the persons who experienced these overdose reactions were using the drug solely for its euphoric effects.

A far more disturbing set of figures involves the known fatalities from accidental methaqualone overdose in Dade County during this period (Table 5). Of these cases, a disproportionate number of males were represented, and all of the individuals were ages 21 years or less. Furthermore, most of these acute fatal reactions occurred in combination with some other central nervous system depressing agent.

Comment

In retrospect, the abuse potential of methaqualone as well as its liability as a dangerous drug has been clearly indicated through extensive testing in the streets. The use and abuse of the drug has increased dramatically during the past 24 months, due largely to the mistaken belief that methaqualone represented a "safe" alternative to barbiturates, combined with the reported drug-seeking patterns of "drug-use-habituated" youths who switched to the next most available drug when amphetamine supplies disappeared from the streets. Increases in the chemical casualties resulting from methaqualone abuse have already become manifest. The number of nonfatal reactions to this form of drug misuse treated at Jackson Memorial Hospital during the first quarter of 1973 expanded by some 300% over that of the corresponding 1972 period. And such increases are likely to continue for as long as public apathy and attitudes offer hospitality to borderline practices in the manufacture, distribution, prescribing and dispensing of methaqualone.

References are available upon request from the authors.

▶ Dr. Inciardi, 16201 S.W. 95th Avenue, Miami 33157.

An ugly thing is only a challenge to someone who cares enough to make it beautiful.

Ovarian Pregnancy With Intrauterine Devices In Situ

Lewis J. Ledden, M.D. and James A. Rawls Jr., M.D.

Abstract: A new case of ovarian pregnancy in situ, associated with an intrauterine device is described. Spiegelberg's criteria for the diagnosis of ovarion pregnancy is met, and the relationship between ovarian pregnancies and in situ I.U.D.'s are discussed in an attempt to show that ovarian pregnancy is increased by the use of the intrauterine device.

Increasing numbers of ectopic pregnancies, including ovarian and even abdominal, have been reported lately suggesting a higher rate of abnormal pregnancies in women who have been wearing intrauterine devices.[1]

Primary ovarian pregnancy is considered as one of the rarest types of ectopic pregnancies. According to statistics, it occurs 0.7 per 100 ectopic pregnancies or about 1 in 40,000 deliveries.[2] Recent studies indicate that women who are using an intrauterine device seem to have higher incidence of ovarian pregnancy. According to Tietze, in a statistical program reported in 1966, the ratio of ovarian to ectopic pregnancy was found to be about 1 to 9, whereas in the general population it was 1 in 200.[3]

In 1878, Spiegelberg formulated his criteria for the diagnosis of ovarian pregnancy. He required: "(1) that the tube on the affected side be intact; (2) that the fetal sac occupy the position of the ovary; (3) that it be connected to the uterus by the ovarian ligament; and (4) that definite ovarian tissue be found in its wall."[4]

Case Report

The patient was 28-years-old, married, and had one normal delivery. Her last menstrual period was approximately October 1 and somewhat shorter and lighter in flow than usual; however, her September period had been completely normal. She was admitted to Doctors Memorial Hospital on November 6, 1972, with severe lower abdominal pains of three weeks duration. She also had been spotting vaginally for three days prior to admission and complained of dyspareunia of six weeks duration. She had been fitted with a Dalkon Shield by her family physician in April 1972 and had no complications. Her past history, otherwise, was of little value. When admitted, her blood pressure was 110/80 and pulse 72 beats per minute. The uterus was normal in size, anteflexed, and tender on palpation and on moving the cervix. The thread of the I.U.D. was barely seen projecting through the external os, and the I.U.D. was removed on initial examination. The cul-de-sac was not bulging. The pregnancy test was positive. A questionable, tender area was found in the lower right abdomen about 6 to 7 cm in size. The pain in the lower abdomen continued.

The patient was taken to the operating room and examined under anesthesia. A mass was found in the lower right quadrant measuring about 6 to 7 cm. A tentative diagnosis of unruptured ectopic pregnancy was made, and she was opened through a Pfannensteil incision. Both uterine tubes were located and found to be completely normal. An unruptured mass was located within the right ovary. The left ovary was identified and found to be normal. The mass was attached to the broad ligament by the mesovarium. The ovarian ligament was located and identified. A right salpingo-oophorectomy was performed. Her hospital stay was completely uneventful, and she was discharged on the 6th postoperative day.

Pathology

The specimen consisted of a right ovary and tube. The right ovary was a hemorrhagic, soft tissue mass that measured 6 x 4.5 x 3.7 cm in greatest overall dimensions. A normal fallopian tube was attached which measured 3.5 x 1.5 x 1.0 cm. The ovary contained a cystic area which grossly resembled an amniotic sac. On microscopic examination, sections of the hemorrhagic mass showed the presence of decidual tissue and chorionic elements with extensive necrosis. Fetal parts were also present. Deeper sections of the paraffin block were cut making a total of three slides available. The examination revealed primordial follicles to be present among the preexisting ovarian stromal elements adjacent to the areas of decidual change.

Discussion

Since the use of intrauterine devices has become more and more popular, an increase in ovarian and ectopic pregnancies has been noted.

The ratio has been quoted as one ovarian pregnancy to every nine ectopic pregnancies, whereas in the general population it is 1 to 200 ectopic pregnancies.[3]

The mode of action of the intrauterine devices has never been fully understood, according to Marston and Kelly.[5] The intrauterine device acts as a foreign body in the uterus producing leukocytic infiltration and a hostile environment to the implanting ovum. Sagirogla has presented his belief that macrophages accumulate which phagocytize spermatozoa in the uterine cavity.[6] Other investigators agree that a local endometrial inflammatory response to the intrauterine device prevents conception.[7] It is highly probable that the intrauterine device prevents pregnancy by altering the uterine environment and making it hostile to implantation.[8] This postulated mechanism of action for the device explains the decrease in intrauterine pregnancies seen with this method of contraception. Ectopic pregnancies are not prevented to as great an extent since the intrauterine device functions inside the uterus.[9] When conception occurs with the intrauterine device in situ, the chance of an ectopic pregnancy apparently increases because uterine conception decreases.

Thus, in the initial workup of a new obstetrical patient, the contraceptive history should be obtained. Intrauterine contraceptive devices combined with equivocal uterine size in the first trimester, associated with a unilateral mass, positive pregnancy test, and pain should alert the physician to the possibility of an abdominal or ovarian pregnancy.

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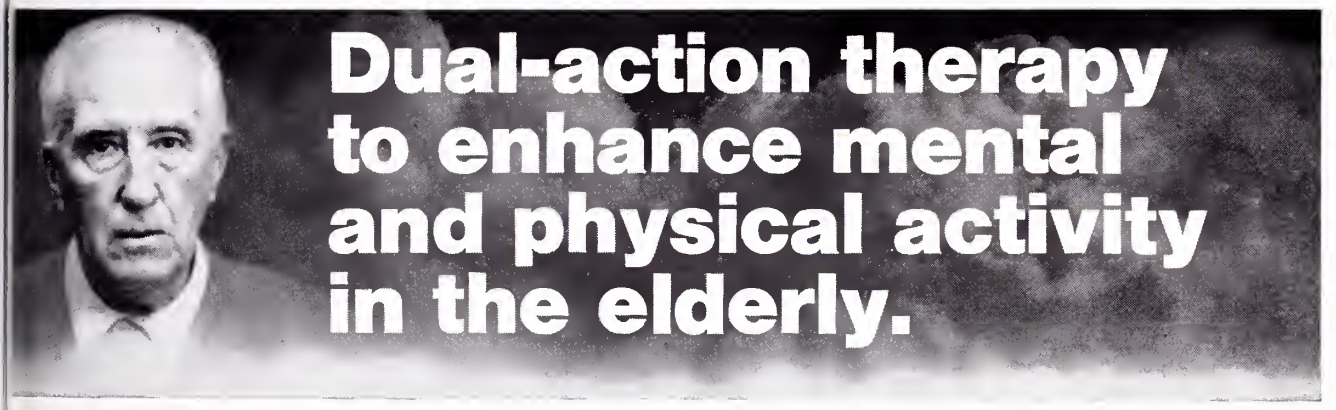

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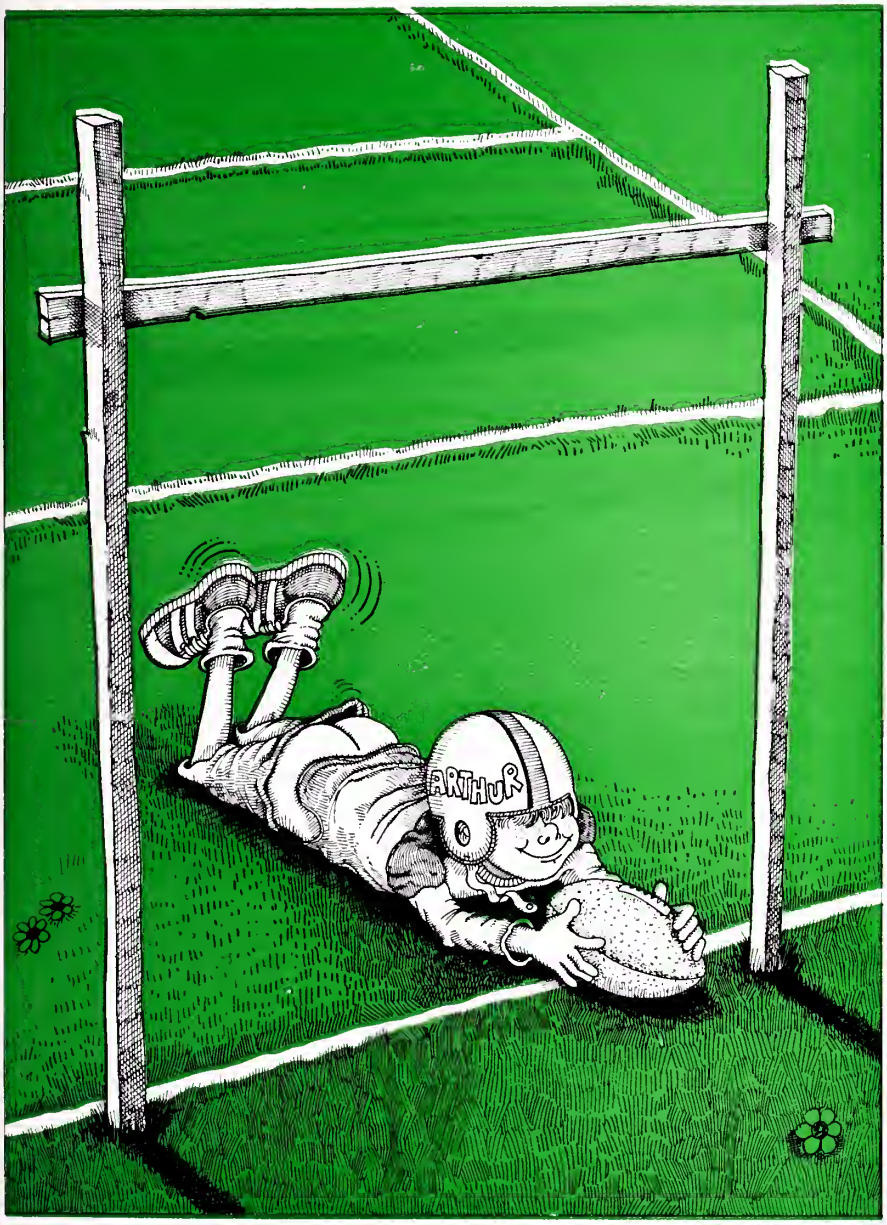

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Special Articles

Florida Physicians Association, Inc.

Jack A. MaCris, M.D.

The Medicare Law, when enacted, specifically stated that there would be no interference in the care of patients by their physicians. Two years ago the Board of Governors of the Florida Medical Association reviewed our experience with Medicare and became alarmed at the encroachment upon medical care, the freedom of the individual physician to care for his patients, and the ensuing unilateral regulations coming from HEW without consultation with physicians. At the same time, the political climate favoring a national health scheme of some sort appeared to be on the increase. Also, the Canadian doctors were then in the throes of their take-over by the government, and as their colleagues in England had said 25 years ago, had they been better prepared to act in unison they would have fared much better in their dealings with the government. Alarmed at what their analysis of the situation suggested, it was apparent that the FMA could be limited in its activities on behalf of the private practice of medicine, or should such activities be pursued in the face of a direct confrontation, an unfavorable court decision could threaten the entire structure of the FMA. Therefore, in their foresight, the Board of Governors appointed a committee to investigate the advisability and feasibility of establishing a separate expendable organization which could act as a protective buffer between the government and the FMA. The Committee studied the situation, and reported back to the Board of Governors, who thought that it was not only advisable but necessary that such an organization be formed, and so directed the committee to proceed in this direction; thus, the Florida Physicians Association, Inc. came into being. Last May a Board of Directors and elected officers were seated, and the FPA became a viable organization. For such an organization to succeed, it must have members. The greater the membership, the greater its voice.

If we have learned nothing else from Medicare, it is that physicians do not control the government program, nor are they consulted in its administration by the bureaucrats. Our fees were frozen at the 1971 level without consulting physicians. Utilization Review Boards of government employees are carrying out retroactive review a month after a patient leaves the hospital, overriding local Utilization Review Committees of physicians' recommendations, and denying payment to the hospital. Furthermore, the hospital is prevented from seeking payment from the patient. At the same time, Senator Kennedy, in his speeches, is telling the public that the doctors' Utilization Review Committees are pushing the elderly sick out of the hospitals.

PSRO is now being foisted upon us, and its wider scope of activities threaten an even greater encroachment upon the private practice of medicine. The Florida Medical Association, in reviewing PSRO, made one request: that the State be considered as a single unit. This has been flatly rejected by HEW. As of this writing, the Federal Register contains the outline of preadmission certification panels made up of staff physicians, which would decide which of their colleagues' patients deserve admission to the hospital.

At the present time, several bills regarding a national health scheme are before the Congress. Our administration has promised us some kind of a bill dealing with national health insurance before the year's end. Health Maintenance Organizations (HMO) are now being funded with your tax dollars to encourage capitation-type medical care.

The attack on the private practice of medicine is the strongest ever and appears to be gaining momentum. If the FPA is to have an effective voice, we must have your support. We urge you to join today. Applications are available through your county medical society office, or by writing directly to the FPA, Box 2411, Jacksonville, Florida 32203. Do it now!

Dr. MaCris is Vice President of the Florida Physicians Association and member of FMA Board of Governors.

Presented before the FMA Sixteenth Annual Leadership Conference, Orlando, January 26, 1974.

▶ Dr. MaCris, 735 Twelfth Street, N., St. Petersburg 33705.

Our House of Delegates — Read How it Works!

FRANKLIN J. EVANS, M.D., LL.B.

It is all spelled out clearly and concisely in the Charter and By-Laws of the Florida Medical Association. But who reads the Charter and By-Laws? Perhaps it is for this reason that several requests were made, after my dissertation on the House of Delegates at the FMA Leadership Conference in Orlando in January, that I prepare for publication a resume of the provisions of the By-Laws pertaining to the organization, functions, and duties of the House of Delegates. My answer was, why not? So here it is for the benefit of the membership of the FMA, more especially for those members of the constituent county societies who will be representing their societies as Delegates in the FMA House of Delegates.

The House of Delegates is a creature of the FMA By-Laws, owing its existence to Chapter IV of the By-Laws. It is the legislative, business and policy-making body of the Association, and its membership consists of the delegates officially elected by the component county societies, and the Speaker and Vice-Speaker (Sec. 1). Each component society is entitled to send annually to each meeting of the House of Delegates one delegate for every forty (40) active members of the Association within that society, and one for every fraction thereof, so that every component society is entitled to at least one delegate. The House of Delegates is limited as nearly as possible to a maximum of 250 regularly elected members from the county societies, and it is the responsibility of the Board of Governors to determine the ratio of delegates to active members to accomplish this limit (Sec. 6). To date, the House has not reached its maximum membership and no reapportionment has been necessary.

The By-Laws provide for an annual meeting of the House of Delegates to be held in conjunction with the annual meeting of the Florida Medical Association. The House selects the site of the meeting, acting upon the recommendation of the Board of Governors (Sec. 2). Special meetings of the House may be called by the President. The latter is *required* to call a special meeting of the House of Delegates upon written request of:

1. 10% of the current delegates.
2. Any 50 active members of the FMA.
3. Three or more component societies.
4. Three-fourths vote of the Board of Governors.

If the President fails to respond to such request, the Speaker is authorized to call such a meeting (Sec. 3).

As stated earlier, the House of Delegates is the legislative, business and policy-making body of the Association. It considers all actions of the Board of Governors, all reports of officers, commissions, and committees, all resolutions, all By-Laws changes, all requests for component chapter charters, and all other proposals and items of business. So those few disgruntled or cynical members of FMA who proclaim that the Association "is run by a couple of guys up in Jacksonville" don't know their By-Laws. "Those couple of guys up in Jacksonville" are strictly accountable to the House of Delegates.

Certain rules of procedure are outlined in the By-Laws. A delegate, once seated, cannot be replaced by an alternate delegate (Sec. 11). Any seated delegate is privileged to vote on any question before the House, but must be present to vote in person. Proxy voting is prohibited (Sec. 13). The privilege of the floor is restricted to seated delegates, officers, members of the Board of Governors, AMA delegates, past presidents, members of the Council on Specialty Medicine, and AMA past presidents who are FMA members, except by permission of the presiding officer. This privilege includes the right to make motions, but these must be seconded by a voting member of the House (Sec. 14).

As you know, the major work of the House of Delegates, the actual gut work, is done by its Reference Committees. Sec. 15 sets forth in detail the composition and functions of the Reference Committees. The latter are appointed from the membership of the House by the Speaker in consultation with the President. The Speaker designates one member of each Reference Com-

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Dr. Evans is Speaker of the FMA House of Delegates.
Presented before the FMA Sixteenth Annual Leadership Conference, Orlando, January 26, 1974.

mittee to serve as Chairman. It has always been the aim of the Speaker and President to have represented on each Reference Committee at least one delegate from each of our medical districts, so as to insure state-wide representation on each Committee. The only limitation imposed by the By-Laws is that officers and members of the Board of Governors may not serve on these Committees. All reports (including those of the Board of Governors), resolutions, measures, proposals and other items of business presented to the House of Delegates are referred by the Speaker to the appropriate reference committee which considers these in depth, permitting all eligible members an opportunity to be heard on any issue under consideration. After the hearings are completed, each committee draws up its report and the Chairman reports the recommendations of his Reference Committee to the House of Delegates at a subsequent session.

Reference Committee attendance at any meeting is restricted to members of the FMA, other doctors of medicine who are guests of the Association, members of the FMA staff required to assist the Committee, and only such other individuals who are invited by officers of the Association or by the Reference Committee itself.

All officers of the Association are elected annually by the House of Delegates. Any active member of the Association in good standing is eligible to hold office. However, the Speaker and the Vice Speaker of the House of Delegates "shall be elected by the House of Delegates from its membership . . . . " (Art. VI, Sec. 7). Thus, if you aspire to be Speaker of the House some day, you must be a member of the House of Delegates. But to be President, you must merely be an active member of the Association in good standing. Yet, in my more than 20 years in the House of Delegates, I do not recall a single President who was not a member of the House at the time of his election. So maybe it's best to become a member of the House before seeking the Presidency.

One might gather from the foregoing that in the House of Delegates rests the final word on all actions of the Association and that its authority is supreme. Not so! Those who framed the By-Laws were wise in reserving the final authority in the membership of FMA. Chapter XVI, Sec. 1 provides for appeals by referendum to the active membership of an action taken by the House of Delegates upon requests and approval of two-thirds of the delegates present and voting. And Sec. 2 states "In similar manner the active membership in General Session, and comprising a minimum of ten per cent of the total number of active members, may direct a general referendum on any action of the House of Delegates upon approval of two-thirds of the members present and voting." Finally, a majority vote of the active members of the Association by direct ballot can revoke an action of the House of Delegates (except an amendment to the Charter and By-Laws which must be handled as outlined in Chapter XIV—Amendments). Thus, you see that the final authority rests with the general membership of FMA—and what could be more democratic than that!

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Physician Overpopulation

VERNON B. ASTLER, M.D.

It is a pleasure to be asked to speak before such a selective and informed audience. Among you are the leading physicians in Florida and the ones who are most qualified to shape the destiny of medicine in our state.

We are reminded almost daily, by the media of the "doctor shortage" and the "health care crisis." At the federal and state level, legislators, educators, and health planners are responding to these charges and possibly we are overreacting. I should like to give you some thoughts concerning these matters, some of which are not original.

I am not an academician, a legislator or a health planner, and I don't know how they think. I am a practitioner and I do know how they think.

I also find myself interested and involved in organized medicine and I know how organized medicine thinks and reacts. I often have the feeling that planners and "do-gooders" generally do their planning and thinking from the safety of a structured environment; they do not know what it is like to be out in practice and all that it entails. We must be extremely careful in allowing anyone to set up rigid examinations for competence and performance which could result in loss of license and livelihood for good practitioners. It is much better to have continuing education requirements on a voluntary basis and depend upon one's pride in his work and profession as the primary stimulus for maintaining competency.

"Health Delivery" is not a neat package amenable to programming and automation or to exact measurements; it is the result of a complicated interaction between and among human beings. Every physician, in possession of his mental and physical faculties and integrity, has his place in caring for citizens. The most important thing is for him to know his limitations and not do what he cannot do; in other words, to know what he does not know.

I would strongly advise against developing any sort of competence and proficiency test into the statutes; this could prove tragic by removing many good physicians arbitrarily.[1]

Historically, the earliest medical licensure and regulation was in 1828 in the Territory of Florida. There existed an act providing for a board to examine early prospective physicians for the protection of the public. It is of interest that this act was repealed three years later. In 1845, when Florida became a state, the examining board was re-established. This board did not have complete authority, since a physician could still file a diploma with the county clerk and negotiate a certificate signed by two practicing physicians and be recognized to practice.

By legislative act signed by the Governor on May 15, 1905, the regular Board of Medical Examiners was created. This Board was composed of seven members which first met on July 27, 1905, and adopted rules and regulations. Subsequently, they met and conducted licensure examinations semi-annually through December 1920.[1]

A newspaper clipping gave the impression that there were four other boards licensing practitioners of the healing arts other than graduates of approved medical schools. The gist of this information was that these schools were "diploma mills" and as a result a disgraceful situation existed in Florida. Only the regular Board of Medical Examiners required examinations for licensure of graduates of approved medical schools.

No doubt responding to this deplorable state of affairs, the Florida Legislature, in 1921, created the present State Board of Medical Examiners, composed of 10 members, all MD's, graduates of approved medical schools, and appointed by the Governor.

How has the Medical Practice Act been amended since these early days? I can assure you that the trend has been one of relaxation and permissiveness to legislative amendments. For example:

1. In 1969 the basic science examination was abolished.
2. In 1972 the citizenship requirement for licensure was eliminated and a simple declaration of an intent to become a citizen was sufficient. Also, graduates of unap-

Dr. Astler, Immediate Past President, Florida State Board of Medical Examiners and member of FMA Board of Governors.

Presented before the FMA Sixteenth Annual Leadership Conference, Orlando, January 26, 1974.

proved medical schools could be accepted for examination if they were certified by an AMA approved specialty board.

3. In 1971 licensure was allowed by endorsement with the National Board of Medical Examiners and with the Federation of Licensing Examinations (FLEX) if obtained within eight years.
   I might add FLEX is now used in 48 states as their testing examination.
4. In 1971 academic licenses for faculty members of Florida medical schools were allowed for a one year period non-renewable.
5. In 1971 an amendment passed allowing certification of physicians assistants by the board.
6. In 1973 a certificate to practice in an area of need was allowed on a year to year basis without written examination if the applicant met certain requirements.

Now what have all of these changes done to the medical manpower pool in Florida?

1. The number of physicians licensed yearly has increased from 300-400 in the 1950's to 1,500 to 2,000 in the 1970's.
2. Florida ranks among the first five states in numbers of physicians licensed.
3. In 1963, there were 5,672 MD's registered within the state and the population was 5,633,000. In 1973, there were 10,790 MD's in the state and the population is 7,404,300. There are in addition, approximately 8,000 additional Florida licensed MD's who are practicing in other states.
4. Figures indicate an increasing trend toward licensure by endorsement. There were 134 licenses issued by endorsement in 1971; 490 in 1972; and 669 in 1973.
   Licenses by examination reached a peak figure of 2,592 examined and 1,961 licenses issued in 1971.

Foreign Medical Graduates

It is perhaps unfair to lump all foreign medical graduates together. We know certain foreign countries have a totally different system of health delivery and others very similar to that existing in the United States. Our job, as medical examiners, is to assure quality over quantity in selecting those foreign graduates who can and are adding to high class health care. The following figures indicate the magnitude of the job.

1. The AMA reported 62,000 FMG's or one fifth of the active U.S. MD's in 1971. (many others here are not registered.)
2. FMG's since 1967 are flooding the U.S. in numbers exceeding the total annual output of all the U.S. medical schools.
3. FMG's already make up one third of all residents in training in American hospitals.
4. In 1971, 13 states and the District of Columbia issued more licenses to FMG's than to U.S. graduates.
5. In 1971, only three of Delaware's 41 newly licensed MD's were U.S. graduates and only 10 of Maine's 121 new MD's went to American schools.
6. One fourth of the Philippine doctors and one fifth of Korea's doctors are in America.[4]
   Recently, I'm told, a new medical school in Thailand graduated its first class and most of the fledgling doctors chartered a plane and flew to the U.S.

So you can see there is a brain drain and perhaps we are exploiting the medical manpower of some of these foreign countries needlessly, and I say needlessly advisedly.

What about medical manpower in the U.S. and the "doctor shortage"? I feel much of this so-called shortage is contrived, and I'll tell you why.

First.— Federal spending for health manpower programs increased from $65 million/year to $536 million/year in the past 10 years. The 10-year cumulative total is nearly $3.5 billion (not including research grants and reimbursement for services).

Secondly.—If the U.S. merely maintains its current output by health professional institutions, in 1985 we will have: 50% more physicians, 40% more dentists and 60% more registered nurses than in 1970.

Thirdly.— This should change our physician population ratio as follows: 1960—140 MD's/100,000 population; 1970—160 MD's/100,000 population; 1985—220 MD's/100,000 population; or **2.2 physicians/1000 people.**[2]

Thus, it seems apparent that rather than heading for a shortage of physicians, we are heading for a surplus. Population growth rates are de-

clining and there appear to be methods to improve productivity of physicians. I need not point out there are some serious disadvantages to having too many doctors. First, our money could be used more effectively elsewhere, and secondly, more doctors may well create more demand, and increase health care costs rather than decreasing them.[2] Our problems do not seem to relate to aggregate numbers of physicians, but rather to physician productivity and maldistribution with regard to both specialty and geographic location.

Physicians Assistants

We now recognize between 30 and 40 schools approved by the AMA for training Physician Assistants and have already certified 28 in Florida. You might be surprised to learn that only North Carolina has certified more.

In conclusion, I would say I am not a statistician or a clairvoyant, but I do know how practicing doctors think. Your medical board tries to represent the feelings of Florida doctors in assuring quality health delivery to the citizens of our state. I know a recent poll revealed that the American people hold physicians in higher esteem than any other group—including lawyers, politicians, government officials, and even clergymen. I believe the access to health care is here and it is the responsibility of the individual to open that access door. America's greatest health problems today are caused by many factors *not* directly related to physicians. Among such factors are obesity, alcohol, tobacco, vehicular accidents, lack of exercise, drug usage, air and water pollution, poor housing, poor nutrition, unsatisfactory emotional life styles, and quackery.[3]

I can envision medical care turning into a kind of public utility, with inferior care, higher costs and many shortages. It's the old, old story of national health schemes driving up costs, driving down quality, and driving out physicians.[3]

I am reminded of Ambrose Bierce's definition of a physician in his "Devils Dictionary" as "one upon whom we set our hopes when we are ill, and our dogs when we are well."

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Editor's Note: To entice you to Hollywood next month for the 100th Annual Meeting of the Florida Medical Association, we solicited two articles for food lovers from experts in the area. To make your stay more pleasant at the meetings, reprints of these articles will be available at the registration desk in the Diplomat. Dr. Richard Fleming's article will appear in the May issue.

Restaurants of the Gold Coast

CHARLES A. MONNIN JR., M.D.

Bailli of Florida and Greater Miami, Confrerie de la Chaine des Rotisseurs.

There is more to a convention than meetings, as we know. Now, let's discuss the wining and dining. Here is a list of a few of the restaurants that many of my colleagues and I have found most enjoyable.

Some restaurants are large, some are small but we have tried them all. A few we did not mention for various reasons. (Would you believe *some* are closed!).

Those with a star denote their excellence BUT CAN BE EXPENSIVE! But do not be afraid to test their excellence as it is well worth it.

En Vino Veritas

Start in the area around the Diplomat, Hollywood-Ft. Lauderdale area, as this is close to the convention area.

***Diplomat** — Celebrity Room — The refined elegance of this intimate dining room comes alive with the golden strings of Michael Kent and his orchestra. Emphasis on continental cuisine and service. Tableside expertise by your host and Maitre d' Don Brooks.

***La Normandie Restaurant** (Headquarters of Les Amis du Vin) 129 North Federal Highway, U.S. I, Dania, Fla.
Phone: 927-1889
Finest French Norman restaurant
Charles and Nora Fredy, Owners

***Dome of the Four Seasons.** In north Ft. Lauderdale. Maitre d' Pierre. Wine cellar insulated with 18" of cork on all four sides, top and bottom.

Venetian Room on top of the Sheraton Hotel in Ft. Lauderdale is excellent in both food and atmosphere.

Moonraker located on an inland waterway is superb steak and chop house with an unusual atmosphere on the inland waterway.
3001 East Oakland Park Blvd.
Ft. Lauderdale
Phone: 563-1211
Warren E. Foster, Owner

The Down Under across from the Moonraker is an interesting restaurant. (Again you are on the waterfront). This is *very* popular.

Cafe de Paris is a small French restaurant in Ft. Lauderdale.
715-A East Las Olas Blvd.
Phone: 523-2900

Cafe de Beaujolais in Ft. Lauderdale is a small French restaurant.
34 N.E. 9th Street
Phone: 566-1416

Mai-Kai-Cantonese Cuisine. Famous for rum drinks and floor show.
Open daily 5 p.m. to 4 a.m.
3599 North Federal Highway
Oakland Park
Phone: 365-6777

Red Coach Grill has three locations for you to enjoy the Maine lobster or steak plus their Thursday night specialties.
(Dinner only)
1200 North Federal Highway
Ft. Lauderdale
Phone: 564-0432

1455 Biscayne Blvd.
Miami
Phone: 379-4008

18050 Collins Avenue
Miami Beach
Phone: 949-5466

South Pacific Polynesian Restaurant. Cantonese cuisine. Nightly entertainment. Just a few minutes away.
711 North Federal Highway
Hallandale
Miami phone: 949-6457

Now let's travel more in the Miami Beach area

***Fontainebleau**—Club Gigi. Maitre d' Geno. A most eloquent atmosphere for wining, dining and dancing. Executive chef, Bill Fleishman, who personally supervises the cooking for the Club Gigi, has probably served more famous people, gourmet societies, and just interesting people than you can imagine, and he will be glad to assist any time.
54th and Collins Avenue
Miami Beach
Phone: 538-8811

***Bernard's Carriage House Restaurant.** Executive Chef, Heinz Warich offers a varied continental menu. Still great, in spite of the fact that Bernard is no longer with them.
54th and Collins Avenue
Miami Beach
Phone: 864-4804
Reservations are a must. Open daily 11 a.m. for lunch; 6:30 p.m. for dinner, except Monday.

Post and Paddock—restaurant and lounge. Very popular locally and preferred by visitors; intimate and sophisticated; horsy decor. Cuisine for the epicure. Open for lunch and dinner
9650 East Bay Harbor Drive
Bay Harbor Island
Phone: 866-8706

Golden Greek Restaurant—Among the few restaurants with Greek cuisine.
12500 Biscayne Boulevard
Miami Beach
Phone: 893-1177

Sneaky Pete. For food and fun (continuous entertainment) nightly from 5 p.m. to 5 a.m. Easy to find—just opposite Gulfstream Park.
1010 South Federal Highway (U.S. 1)
Hallandale
Phone: 944-7197

Nick and Arthur's. For atmosphere and good food, and a reservation of course, try one of their delicious steaks.
1601 North 79th Street Causeway
North Bay Village
Phone: 866-9759

The Cattleman. Known as the adult Western restaurant. Located where Broad Causeway meets Biscayne Boulevard at 124th Street. Known for its steaks.
1800 North East 124th Street
North Miami Beach
Phone: 891-1600

***Cafe Chauveron of Florida, Inc.** New restaurant in the Bay Harbor area. French cuisine and extensive wine cellar. Outdoor terrace for cocktails adjacent to dock accommodating yachts. Reservations are a must.
9561 East Bay Harbor Drive
Bay Harbor Island
Phone: 866-8779

The Forge Restaurant and Lounge. Specializing in steaks and prime rib. Dinner and supper. Open 6 p.m. to 3 a.m. Reservations suggested.
423 Arthur Godfrey Road
Miami Beach
Phone: 538-8533

Joe's Stone Crab Restaurant. Noted for stone crabs but also serves steaks and chops. One of our oldest institutions in this area.
227 Biscayne Street
Miami Beach
Phone: 673-0365

Miami

Valenti's Italian cuisine is well known to all who have passed through the thresholds of Jackson Memorial Hospital.
Miami
Phone: 324-7661

Benihana of Tokyo Steak House.
79th Street Causeway
North Bay Village
Miami
Phone: 866-2768

Rusty's Pelican Restaurant. Good food, good service and fantastic view. Open 11:30 a.m. to 11:30 p.m.
99 Rickenbacker Causeway
Miami
Phone: 361-5753

Prince Hamlet. Owner/Chef Jorgen Muller. Famous for Danish cuisine. Open 5 p.m. to 10:00 p.m. Meeting place for many Gourmet Clubs. Open every day. Reservations suggested.
8301 Biscayne Boulevard
Miami
Phone: 757-5541

Casa Santino. Northern Italian and Roman cuisine. Gourmet dining in seven dining rooms or the famous Wine Cellar. Strolling minstrels and piano bar nightly.
10999 Biscayne Boulevard
Miami
Phone: 895-1440

***Raimondo's** is another exceptional Italian dining room where food is cooked to order (do not hurry). Famous for its classical Italian recipes. Raimondo, chef Maitre d' Rotisseur and Maitre d' Luigi. Among other things, he is famous for the multiplicity of the gourmet clubs he continues to entertain yearly.
201 N.W. 79th Street
Miami
Phone: 759-9403

Cuban restaurants noted for their colorful floor shows and excellent Latin cuisine. I must say that there are many excellent Cuban restaurants in our area, probably secondary to none anywhere: here, Spain, etc.—as a matter of fact, I have never found a bad Cuban restaurant in Miami.

Les Violins
1751 Biscayne Boulevard
Miami
Phone: 371-8668

Flamenco Supper Club
911 N. E. 79th Street
Miami
Phone: 751-8631

Miami Springs

Miami Springs Villas. Take your choice of any of the 18 dining rooms. President, Art Bruns, who has been host to presidents and astronauts and who has personally raised hundreds of thousands of dollars for Variety Children's Hospital is a good friend of our medical profession. Among the best known are the following four:

***The Original Japanese Steak House.** Chopsticks if your talent is there, or instructions. Prepared in front of you by the Japanese who know how.
500 Deer Run
Miami Springs
Phone: 871-6000

***King Arthur Court.** Go back in history with his knights of the roundtable (each table has the name of a knight). Add to the beautiful environment a small waterfall plus strolling violins.
500 Deer Run
Miami Springs
Phone: 871-6000

My Apartment. Small dining area where you cook the steak of your choice at your table.
500 Deer Run
Miami Springs
Phone: 871-6000

If you would like to visit the private **Carriage Club,** ask any of the many doctors who are members or some of the personnel and you can eat, drink and dance.
500 Deer Run
Miami Springs
Phone: 871-6000

Coral Gables

Chez Vendome of the David Williams Hotel.
Maitre d' Mr. Fleming
700 Biltmore Way
Coral Gables
Phone: 443-4646

Coconut Grove Hotel's **Horatio's Rooftop Restaurant.** Maitre d' Luis. Excellent service and outstanding food. Reservations a must.
2649 South Bay Shore Drive
Coral Gables
Phone: 443-3812

In addition to these fine dining places, there are a number of private clubs of which many of us are members and if any of the FMA members would like to go to any of them, arrangements can be made.

▶ Dr. Monnin, 250 Bird Road, Coral Gables 33146.

ABOUT THE AUTHOR: Apart from being the Bailli of Florida and Greater Miami, Confrerie de la Chaine des Rotisseurs, he is also a member of the Physicians Wine Appreciation Society, etc. In 1972 he was a judge of culinary arts in Budapest, Hungary. He is also a Compagnon de Bordeaux and a member of Les Amis du Vin.

Reprints of this list will be available at the FMA Annual Meeting, May 8-12, 1974, Registration Desk, Diplomat Hotel.

"I Don't Take Medicaid..."

Some months ago I sent a really splendid article on Medicaid to our Editor to be published in this Journal. Despite its merit it was rejected on the grounds that it was too long—"doctors only read brief articles." Well, here is a brief article (reading time 36 seconds)—rather unattractive but brief.

I. "I don't accept Medicaid because it doesn't pay enough."
Medicaid now pays the same as Vocational Rehabilitation and this is based on specific conversion factors multiplied by unit values as published in the FMA Relative Value Study. For instance an appendectomy has a unit value of 10 while the conversion factor for surgery is 21. Thus Medicaid will pay $210 for an appendectomy. Another example would be a unilateral lens extraction for a cataract with a unit value of 20—thus paying $420.

II. "I don't accept Medicaid because I don't want anything to do with the government or their programs."
The government is not "they"; it's "us." Us in summation. It is merely that minority group we the majority put in charge. It is not "their" program, it is "ours."

III. "I don't accept Medicaid because there's too much paper work."
Who says so? Have *you* checked on it or are you just taking somebody else's word for it. Actually if you have a good billing clerk you shouldn't know there is any paper work.

IV. "I don't accept Medicaid because there's not enough time allowed to get your bills in for payment."
If there is a good reason that transaction numbers weren't obtained or bills rendered within three months (90 days) of the service rendered a short explanation will get special attention and chances are good the bill can be paid.

V. "I don't accept Medicaid because I don't believe in a Welfare State. People should work in order to pay their own bills."
Florida's Medicaid covers only the "categorically" poor—the aged, the blind, the disabled and those families deprived of a parent's support mainly because of an incapacitating condition—disease or injury. It is noteworthy that these people—incapacitated or totally and permanently disabled—require a physician's statement that they are unable to work before being accepted on the State's welfare rolls.

I don't accept Medicaid—I won't help the aged, the blind, the disabled receive good medical care even though our present society sees fit to help them in their poverty.

I don't accept Medicaid—I'd rather wait for the complete socialization of medicine—like the Kennedy plan to solve all problems. If I helped solve the medical problems of this really small segment of our present society then our present American Medical System might endure forever!

MATTHEW E. MORROW, M.D.
STATE MEDICAL CONSULTANT
DEPARTMENT OF HEALTH & REHABILITATIVE SERVICES
JACKSONVILLE

Editor's Note: Dr. Morrow is acting Chief Medical Consultant (an advisor, not a director) for the State in all matters concerning Medicaid. Having been in active practice in internal medicine before accepting this position, he is in sympathy with some of the problems of the private practitioner. He requests that our readers provide him with written criticism, comments, and questions to strengthen his medical input in this program. A most recent accomplishment was obtaining an incoming WATS-line for the Physicians' section so that billing clerks can talk directly to the "right" person in the State office. His address is P.O. Box 2050, Jacksonville, Florida 32203. C.M.C.

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Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

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When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

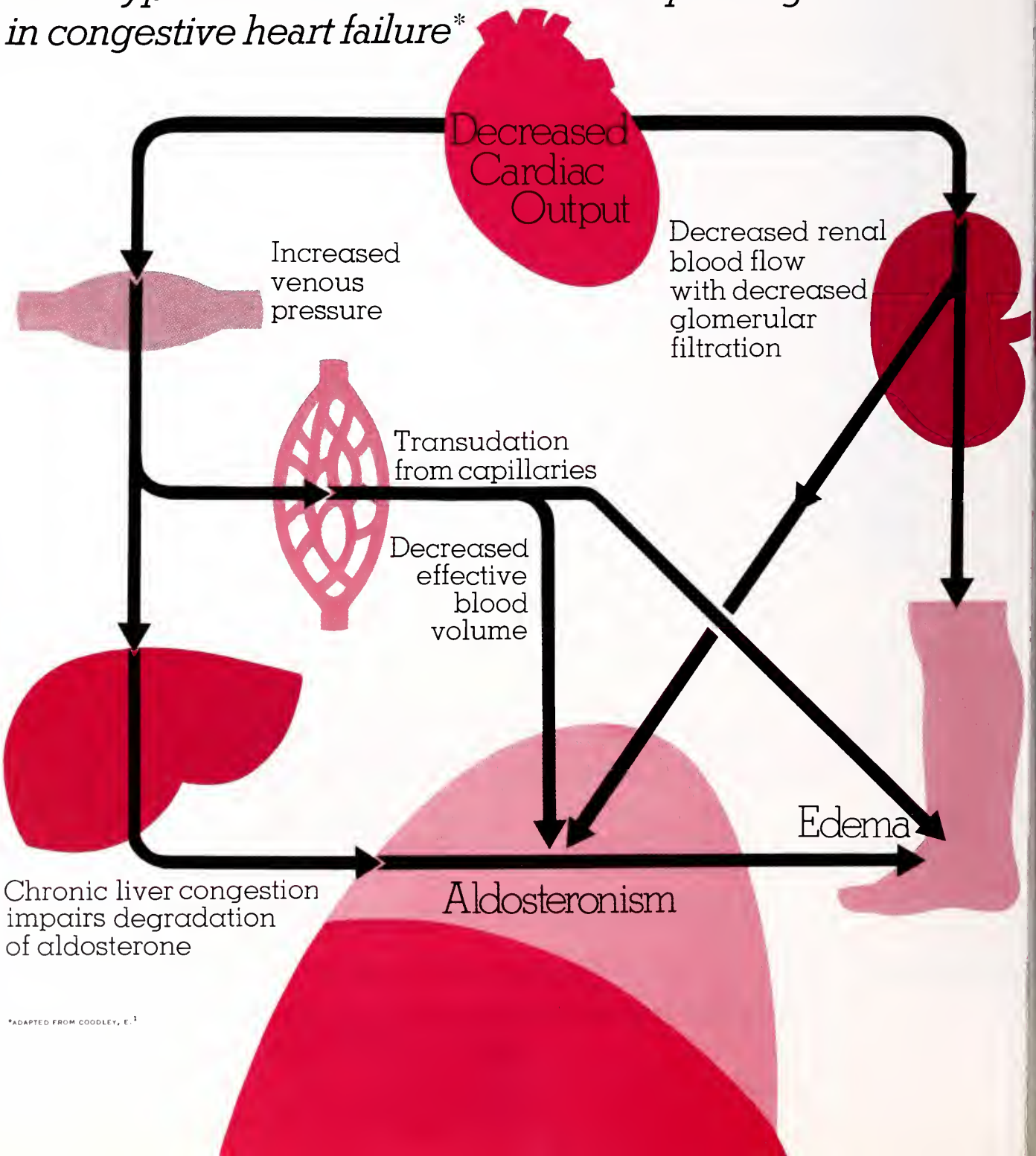
Studies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains are known to be resistant, routine sensitivity testing is recommended.

In congestive heart failure...

secondary aldosteronism

*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**



*ADAPTED FROM COODLEY, E.[1]

is a primary factor

To "switch off" the aldosterone factor in congestive heart failure

Aldactone

brand of

spironolactone 25-mg. tablets

the only specific aldosterone antagonist... basic in all diuretic therapy

Three ways to use Aldactone in congestive heart failure

1. As the only diuretic

- Often sufficient alone.
- Produces gradual, sustained diuresis by blocking aldosterone action in the distal renal tubule.
- Avoids potassium loss.

2. As the basic daily diuretic with an "add-on" alternate-day-diuretic ("A.D.D." schedule)

- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indicotians—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome, idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Cantroindicotians—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of ony drug in women of childbearing age requires that the potential benefits of the drug be weighed ogoinst its possible hozards to the mather ond fetus.**

Precoutions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosoge ond Administrotion—For **essentiol hypertension** in **odults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edemo, oscites or **effusions** in **odults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972

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Address medical inquiries to:
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Medical Department
Box 5110, Chicago, Illinois 60680

311

All of these mammals, except one, can synthesize vitamin C

Woman (man) cannot.

Human beings can neither synthesize vitamin C nor store most of the water soluble vitamins. They should be replenished continuously.

Normally, people accomplish this in their daily diet. But under conditions of illness, stress, in convalescence or following surgery, vitamin stores may be depleted or metabolic demands increased.

In such cases, Surbex-T may be indicated. Surbex-T makes it easy and convenient to restore the water-soluble vitamins. Each tablet provides 500 mg. of vitamin C plus high potency B-complex.

Where nutritional status must be preserved, Surbex-T can help restore what the body *cannot* effectively store. 403482

ABBOTT

SURBEX-T® 500 mg. of Vitamin C with High Potency B-Complex

Restores what the body cannot effectively store

Editorials

A Message to FMA from Mars

Hello earthdocs! I have been observing the activities of the earthdocs from my spaceship. With some difficulty, I have almost learned to communicate the language.

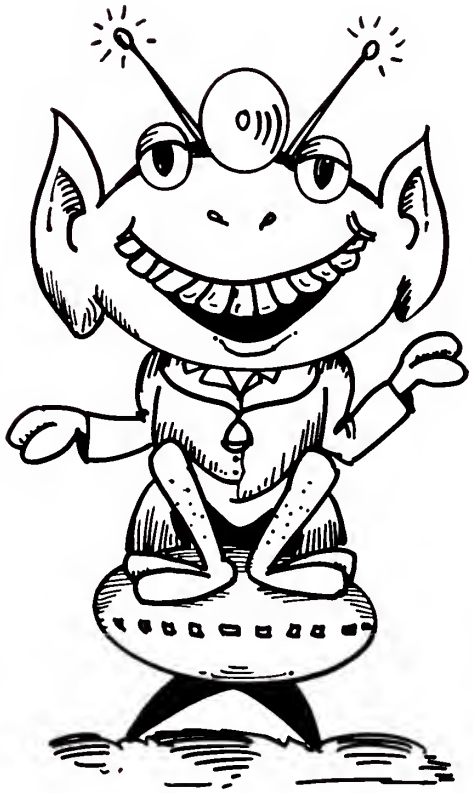
I have flown over the mid-section of the East coast over a city I shall designate as Wet and Swampy Hollow (Washington). There is much discussion in this city and elsewhere about a program called PSRO. The exact mechanism of this program is confusing to me. I will keep a keen watch on the situation and will communicate further when any other significant, interesting, inflationary, or inflammatory developments arise about PSRO.

I will be watching you at your 100th celebration of our medical organization in the state of Flat Land (Florida). In order that you will be able to recognize me, I am sending along a picture. I will recognize you because Martiandocs have special talents for seeing peoples' true nature. This is of special benefit when dealing with one's wife, politicians, colleagues, and, occasionally, patients.

A question has arisen in my mind. Perhaps someone can answer it for me. Why is it that the state of Flat Land with a population of 7.2 million people, a coastline of approximately 1,197 miles, and 58,160 square miles has its conventions in the lower part of the state alternating yearly between hotels approximately 11 miles apart? This seems somewhat curious to me. Does it relate to the opulence and gaudiness of this area? Are there some special benefits to the organization or its leaders? Perhaps the answers will be forthcoming, or, perhaps I may need to call on the Martiandoc talent of seeing the true nature of people in order to answer this question.

Thanks for allowing me to communicate with you. I'll be seeing you!

Most sincerely,
Martiandoc



Martiandoc

Editor's Note: The identity of this Martiandoc is unknown to us but a self portrait was submitted so that Florida physicians might recognize him. As a rule anonymous articles are not accepted but with the increasing interplanetary travel it was thought that the courtesy of the press should be extended to a medical visitor who has raised a question that has been uppermost in the minds of some FMA earthdocs. Older heads realize that other cities have been used with poorer attendance, where lack of hotel rooms have been a factor but times and places are changing.

Substitution or Anti-Substitution

Alleging that savings will be passed on to the patient at no sacrifice in quality, some pharmacists are asserting that they have the right to substitute a different drug product for the one the physician prescribes. As self-styled drug experts, having received five to seven years training in pharmacology, they affirm that they are in as good a position as the physician to make a specific drug selection. Should physicians not be receptive to this idea, they recommend legislation establishing a voluntary formulary of therapeutically equivalent drug products from which the pharmacist is free to dispense an equivalent of the specific product prescribed. Another alternative is to persuade local area physicians to sign prior consent blanks, thereby granting the pharmacist authority to make the drug product selection, using a generic equivalent even though the physician prescribes the brand name.

The first bar and the one which probably influences most pharmacists not to substitute, is an ethical one binding the pharmacist to dispense precisely what the physician prescribes unless he consults with that physician and receives authorization to modify the original prescription. Secondly, for years, many community pharmacist's proudest boast was that few patients received prescriptions that could not be filled promptly and locally by them. While there is no substantial body of objective data supporting the notion that the use of cheaper drugs is beneficial for the patient's well-being, common sense tells one that seldom are there many instances where the cheapest article is always the most satisfactory. Such emphasis on cost diverts attention from where it should be placed; namely, the effectiveness of the drug product in the patient for the illness diagnosed. As it is only the performance of a specific drug product in the clinically ill patient that warrants serious consideration and as it is only the physician who personally follows the course of the disease and can clearly visualize the influence of the administered therapeutic agent, actually as practice proves the quality performance of drug products, permitting a free market to operate, use will expand and costs drop. What fair minded citizen would want cheaper substituted generic drug products made mandatory for the disadvantaged, a frequently suggested plus value for pro-substitution legislative proposals, and what physician could countenance being a party to two classes of therapy for his patients?

Those intimately involved in pharmaceutical formulation are aware of the fallacy of the concept that chemical equivalency equates with therapeutic activity for there is almost total lack of human or animal data demonstrating biological equivalency of market drug products of different manufacturers. Chemical equivalency and biological activity of similar drug products of differing manufacture are not the same. Since those who predominantly support pro-substitution maneuvers are nonphysicians, unable to recognize the legal and ethical responsibility of the treating physician and since the only health care professionals in any number who favor this plan are the pharmacists who are most likely to do much of the substituting and who have a direct economic interest in all products, it appears that in their adoption, some economic advantage to their commercial activity is the only logical reason for this campaign. While undoubtedly, the pharmacist is a drug expert, in therapy he is an untrained and unqualified interloper and cannot define how substitution will enhance better therapeutic care of the patient, only that it will influence costs. If and when physicians can clearly be shown that all marketed similar drug products are equally safe and effective for specific diagnoses in all patients and if and when the doctor is no longer medico-legally liable for any therapeutic misadventure associated with a drug product substitution, then, and only then, perhaps will he consider substitution. Yet as morally responsible for the diagnosis and treatment of each patient, how can he permit another to select the drugs without his own knowledge and consent? Hence, in the best interest of his patients, he must oppose any legislative maneuvers even suggestive of being pro-substitution in character.

C. M. C.

One More Battle? Or the War?

WALTER W. HAMILTON, M.D.

This PSRO issue is far from over and I hope Florida can be yet another one of our proud United States to finish this noxious law and get it written off the books for good. It can be done! There is congressional support in Washington to accomplish that goal!

With the relentless and intensifying pursuit for the control of our profession and its health services evident from all sides and from all matters of interests, it seems the grass roots are our greatest strength. The private practicing physician is where our strength can be mobilized and believe me, friends and colleagues, the war is on!

These are not alarm reactions—the manure has started to hit the fan—and some of the same so-called "splinter groups" can very well save our honored profession and preserve the kind of health care our patients have known—the best in the world.

Events to date in this mess demand a complete reconsideration of our position on PSRO. Our FMA president has suggested this and I totally agree. There should be complete disclosure and discussion of all information bearing on PSRO and its related subjects by and for the full membership of the House of Delegates. Other groups should be heard by invitation, if necessary, regardless if they are outsiders, physicians or medical society representatives. In fact, the focus on the entire annual meeting should be medicine—free or government?

We can see already in this state, after two encounters without success, that there is no compromise where HEW is concerned. There will be no local control, not for the men on the line. The January 9 Federal Register trick is only a hint at what plotting, treachery, and malignancy can come from these sources, and we're being asked to cooperate with them! *That* is unbelievable! The AMA Board of Trustees has now stated they will not pursue action to repeal that part of PL 92-603 which created PSROs.

Gradually the American public has been led to believe that the federal government has the right to take over the resources of medicine and force a radical change in medical practice. This thinking is horribly distorted, but allowed to continue would lead medicine beyond the point of no return.

PSRO has been caught up in a bureaucratic quagmire; the policy making and operational features of PSRO have been divided by HEW; haggling between bureaus and agencies is already evident and personnel changes are practically weekly.

PSRO is supposed to "insure accountability and to prevent a decline in the quality of medical care and promulgate standards to be followed by all doctors in the management of every variety of disease." Well, our profession and our patients' health is being tinkered with and a lot of it has been behind closed doors.

The American people have to know somehow, somewhere, what is really happening and it is our responsibility as physicians to tell them. It is our obligation to advise them about matters affecting their health.

Lay individuals, whomever they are, cannot be called upon to control the clinical practice of medicine. In fact, the legal profession says this is intolerable: "Lay control would be intolerable because only physicians can exercise clinical judgment."

I cannot hold another physician in suspect unless I am of the same specialty—and aware of the scope of that specialty—and have examined the patient in consultation. The United States Supreme Court has already stated that interference by anyone else, even a physician, is not necessary or even tolerable. And anyone else having less qualification than those required for licensure trying to practice medicine, is doing so illegally—and this cannot be tolerated. And to ask the American public to pay for it is utterly fantastic!

The AMA testimony before the Senate in 1970 opposed the federal standards and other aspects suggested in PSRO and the content of that testimony is still valid, regardless of what organized medicine has said since.

Medicine must stay unified from the grass roots up. For if we are divided—and we will be if we agree to and participate in PSRO—we will fall, never to be the same again. Patients will never again have private individual personalized medical care as we know it now.

There are many tasks and many battles ahead, but it is most assuredly—war time.

Dr. Hamilton, 432 Pasadena Avenue, S., St. Petersburg 33707.

ORGANIZATION

Annual Meeting Scientific Sections

The following scientific sections will be held during the 1974 Annual Meeting of the Florida Medical Association, May 8-12 in the Diplomat Hotel, Hollywood. Complete programs and time schedules will appear in the official annual meeting program.

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians)
Thursday, May 9
Regency Room South

Roberto Llamas, M.D. and Marvin Sackner, M.D., Miami
Program Co-Chairmen

2:00 p.m. "Nonbacterial Pneumonias," Robert B. Couch, M.D., Professor of Microbiology and Medicine, Baylor College of Medicine, Houston, Texas

3:00 p.m. "Case Presentation of Nonbacterial Pneumonia." Panel Discussion
Chairman—Ross C. Kory, M.D., Chief, Department of Medicine, Tampa VA Hospital, Tampa
Presentor—Bruce Stewart, M.D., Fellow, Pulmonary Division, University of Florida College of Medicine, Gainesville
Discussants—Robert B. Couch, M.D., Houston
Kenneth R. Ratzan, M.D., Division of Infectious Disease, VA Hospital, Miami
Manuel Viamonte Jr., M.D., Chairman, Department of Radiology, University of Miami and Mount Sinai Medical Center, Miami Beach

4:00 p.m. "Coronary Artery Surgery—Indications, Contraindications and the Difficult Decision"
Chairman—Eugene J. Sayfie, M.D., Miami
Discussants: Paul Swaye, M.D., Ernest Traad, M.D., Jonathan Partain, M.D., Lester Nunnally, M.D.

SECTION ON INFECTIOUS DISEASE AND ANTIBIOTICS—Part I

(Presented by FMA Committee on Scientific Assemblies)
Thursday, May 9
Card Room
Robert H. Waldman, M.D., Gainesville
Presiding

1:30 p.m. "Newer Antiobiotics—Use and Misuse," Jay P. Sanford, M.D., Professor of Medicine, Department of Internal Medicine, Southwestern Medical School, Dallas, Texas

2:05 p.m. "Prophylactic Antibiotics and Nosocomial Infections," George Counts, M.D., Assistant Professor of Medicine, University of Miami School of Medicine, Miami

2:40 p.m. "Antibiotic Therapy of Gram Negative Infections," William M. M. Kirby, M.D., Professor of Medicine, University of Washington School of Medicine, Seattle, Washington

3:15 p.m. "Clinical Recognition and Management of Anaerobic Infections," John G. Bartlett, M.D., Infectious Diseases Section, VA Hospital, Sepulveda, California

3:50 p.m. Questions and Answers—Panel

SECTION ON PSYCHIATRY

(Co-sponsored by Council of Florida District Branches of the American Psychiatric Association)
Thursday, May 9
Regency Room East
Roger F. Reinhardt, M.D., Gainesville
and Philip B. Phillips, M.D., Pensacola
Program Chairmen

2:00 p.m. Case Study of a New Department of Psychiatry 1970-1973, Walter E. Afield, M.D., Professor of Psychiatry and former Chairman of Department, University of South Florida, Tampa

2:30 p.m. Problems with the Migratory Patient in Florida, Richard E. Gordon, M.D., Associate Professor of Psychiatry, University of Florida, Gainesville

3:00 p.m. Families of Children in Trouble, Martin W. Denker, M.D., Assistant Professor of Psychiatry and Acting Chairman, University of South Florida, Tampa

3:30 p.m. Psychopharmacology: What's New and Exciting, Geoffrey J. Newstadt, M.D., Assistant Professor of Psychiatry, and Chief, Consultation Service, University of Florida, Gainesville

4:00 p.m. Discussion

SECTION ON SEX AND SEXUALITY

Thursday, May 9
Regency Room North
Masters and Johnson

5:30 p.m. Masters and Johnson
(Dr. William Masters and Mrs. Virginia Johnson, Reproductive Biology Research Foundation, St. Louis, Missouri)

SECTION ON INFECTIOUS DISEASE AND ANTIBIOTICS—Part II

(Presented by FMA Committee on Scientific Assemblies)
Friday, May 10
Card Room
Robert H. Waldman, M.D., Gainesville
Presiding

8:05 a.m. "Oral and Cutaneous Manifestations of Infectious Diseases," George A. Pankey Jr., M.D., Ochsner Clinic, New Orleans, Louisiana

8:40 a.m. "Treatment of Obstetrical and Gynecological Infections," Charles Craig, M.D., University of South Florida College of Medicine, Tampa

9:15 a.m. "Management of Urinary Tract Infections in the Outpatient," Edward H. Kass, M.D., Harvard Medical School, Boston

9:50 a.m. "Detection and Treatment of Infections in the Immunodeficient Patient," Elia M. Ayoub, M.D., Department of Pediatrics, University of Florida College of Medicine, Gainesville

10:25 a.m. Questions and Answers—Panel

SECTION ON INTERNAL MEDICINE

(Co-sponsored by Florida Society of Internal Medicine and Florida Region, American College of Physicians)
Friday, May 10
Regency Room East
Michael J. Pickering, M.D., Lakeland
Program Chairman

8:00 a.m. "Gram Negative Shock," Charles Craig, M.D., Tampa

8:20 a.m. "Status Asthmaticus," Samuel Bukantz, M.D., Tampa

8:40 a.m. "Acute Renal Failure," Dana Shires, M.D., Tampa

9:00 a.m. "Colonoscopy: A New Look at Old Diseases," Arthur I. Gilbert, M.D., Miami

9:15 a.m. Question and Answer Period

9:30 a.m. "Acute Respiratory Failure," Ross Kory, M.D., Tampa

9:50 a.m. "Pulmonary Embolism," Roy Behnke, M.D., Tampa

10:10 a.m. "Ascites," Walter Trudeau, M.D.

10:30 a.m. Question and Answer Period

SECTION ON EMERGENCY MEDICINE

(Co-sponsored by Florida Chapter, American College of Emergency Physicians)
Friday, May 10
Regency Room East
David D. Wells, M.D., Plantation
Program Chairman

2:00 p.m. "Credentials of the Emergency Physician," R. R. Hannas Jr., M.D., President, American College of Emergency Physicians, Oklahoma City, Oklahoma

2:40 p.m. "Use of Blood Gases in the Critically Injured or Ill Patient," Andrew R. Piergeorge, M.D., Miami

3:20 p.m. "Transportation of the Critically Ill Patient," Patrick O'Leary, M.D., Gainesville

4:00 p.m. "Emergency Department Radiology," William R. Nicolay, M.D., Winter Haven

4:40 p.m. Question and Answer period

*SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)
Friday, May 10
Regency Room North
William P. Clarke, M.D., Jacksonville
Program Chairman
"General Office Diagnostic and Surgical Proctology"

2:00 p.m. "Office Colon and Rectal Polyps," Julian Suhrer, M.D., Chief, Section of Proctology, Memorial Hospital, Jacksonville

2:30 p.m. "Newer Methods of Treating Hemorrhoids (cryosurgery, closed technique of local anesthesia)," Cal S. Kellogg, M.D., Associate Professor of Health, Dade Junior College, and Instructor in Family Medicine, University of Miami School of Medicine, Miami

3:00 p.m. "Evaluation and Diagnosis of Hemorrhoidal Problems (evaluation for hemorrhoidectomy and associated problems)," Emmett F. Ferguson, M.D., Clinical Assistant Professor, Department of Surgery, JHEP of the University of Florida College of Medicine, Jacksonville

3:30 p.m. Break

3:40 p.m. Joint Panel Discussion for "Pearls and Hazards in Office Proctology"

*This program is accepted for three prescribed hours by the American Academy of Family Physicians.

SECTION ON ARTHRITIS

(Co-sponsored by Florida Orthopedic Society and the Florida Society of Rheumatology)
Friday, May 10
Seminar Room #2
James F. Richards Jr., M.D., Orlando
Sidney Storch, M.D., Jacksonville
Louis M. Sales, M.D., Jacksonville
Program Co-Chairmen

2:00 p.m. "Gold in the Treatment of Rheumatoid Arthritis," C. Russell Smith, M.D., Watson Clinic, Lakeland

2:20 p.m. "Cell-Mediated Immunity in the Arthritic Diseases," Jacques R. Caldwell, M.D., University of Florida College of Medicine, Gainesville

2:40 p.m. "Mechanisms and Therapy of Paget's Disease," Roy D. Altman, M.D., University of Miami School of Medicine, Miami

3:00 p.m. "Crystal-Induced Arthritides," Norman L. Gottlieb, M.D., University of Miami School of Medicine, Miami

3:20 p.m. "Arthritis Mutilans, Psoriasis," Ben R. Thebaut Jr., M.D., North Palm Beach

3:40 p.m. Coffee Break

3:55 p.m. "The Arthritic Hand and Foot," Alfred B. Swanson, M.D., Grand Rapids, Michigan

4:45 p.m. Panel Discussion

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)
Friday, May 10
Seminar Room #1
Daniel J. Seckinger, M.D., Miami Beach
Program Chairman

4:00 p.m. "Clinical Enzymology—Diagnostic or Otherwise," John Batsakis, M.D., Professor of Pathology and Director of Laboratories, University of Michigan Medical Center, Ann Arbor, Michigan

SECTION ON NEPHROLOGY

(Co-sponsored by Florida Society of Nephrology)
Friday, May 10
Seminar Room #3

2:00 p.m. "Hypertension: Current Concepts of Physiology, Diagnosis and Treatment," Eliseo Perez-Stable, M.D., Chairman, Department of Medicine, VA Hospital, Miami

2:20 p.m. PANEL—Moderator, Joel B. Mann, M.D., Miami
Michael Pickering, M.D., Lakeland
Murray Epstein, M.D., Miami

2:45 p.m. "Prevention and Early Diagnosis of Renal Disease," George A. Richard, M.D., Co-Director of Pediatrics, Renal-Urology Division, University of Florida College of Medicine, Gainesville

3:05 p.m. PANEL—Moderator, Jay Whitworth, M.D., Jacksonville
Jose Strauss, M.D., Professor, Department of Pediatrics, University of Miami School of Medicine, Miami
Carl Goldsmith, M.D., Associate Professor of Medicine, Division of Renal Medicine, University of Miami School of Medicine, Miami

3:30 p.m. Coffee Break

3:40 p.m. "Pre-dialysis Therapy and Reversible Uremia," Sidney Levin, M.D., Jacksonville

4:05 p.m. PANEL—Moderator, John E. Cunio, M.D., Coral Gables
Charles P. Hayes, M.D., Jacksonville
James L. Katsikas, M.D., Assistant Professor of Medicine, University of Miami School of Medicine, Miami

This section is scheduled for 45 minutes with a 25 minute address by Dr. Levin followed by a 20 minute discussion period.

4:25 p.m. "Dialysis and Transplantation," Dana L. Shires Jr., M.D., Associate Professor of Medicine and Chief of Nephrology, University of South Florida College of Medicine, Tampa

4:50 p.m. PANEL—Moderator, Lawrence Kahana, M.D., Tampa
Wm. Way Anderson, M.D., Miami
Robert A. Metzger, M.D., Winter Park

SECTION ON PEDIATRICS, OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Pediatric Society and Florida Obstetric and Gynecologic Society)
Friday, May 10
Congress Room

George A. Richard, M.D., Gainesville and William T. Patton, M.D., Pensacola, Program Co-Chairmen

Introduction: Richard J. Boothby, M.D., Chairman, Fetus and Newborn Committee, Florida Pediatric Society, Jacksonville

Session I "The Impact of Perinatal Centers on Newborn Survival"
Moderator: Edward R. Westmark, M.D., Director, Neonatal Inpatient Care Unit, Sacred Heart Hospital, Pensacola

2:00 p.m. "Perinatal Centers—Rationale and Justification," Edmund A. Egan, M.D., Assistant Professor of Pediatrics, Division of Neonatology, University of Florida College of Medicine, Gainesville
"Maternal and Fetal Care," Robert J. Thompson, M.D., Chairman, Department of Obstetrics-Gynecology, University Hospital of Jacksonville, and Associate Professor, Jacksonville Hospitals Educational Program, University of Florida College of Medicine, Jacksonville
"Neonatal Care," Charles R. Bauer, M.D., Assistant Professor, Department of Pediatrics, University of Miami School of Medicine, Miami
Discussion

3:30 p.m. Break

Session II Moderator: Charles H. Gilliland, M.D., Immediate Past President, Florida Obstetric and Gynecologic Society, Gainesville

3:45 p.m. "The Gynecologic Examination of the Pediatric Patient," Dorothy J. Hicks, M.D., Assistant Professor of Obstetrics-Gynecology, University of Miami School of Medicine, and Director, Pediatric Gynecology Clinic, Jackson Memorial Hospital, Miami

4:00 p.m. "Practical Management of Sexual Ambiguity," Robert S. Stempfel Jr., M.D., Director, Mailman Center for Child Development, and Professor of Pediatrics and Vice Chairman, Department of Pediatrics, University of Miami School of Medicine, Miami

4:15 p.m. "Menstrual Irregularities in the Adolescent," Charles J. Hochberg, M.D., Assistant Professor of Obstetrics-Gynecology, University of South Florida College of Medicine, Tampa

4:30 p.m. Discussion

SECTION ON ALLERGY AND OTOLARYNGOLOGY

(Co-sponsored by Florida Allergy Society and Florida Society of Otolaryngology)
Saturday, May 11
Congress Room

Angelo P. Spoto Jr., M.D., Lakeland, and Theodore M. Hahn, M.D., Pompano Beach
Program Co-Chairmen

8:30 a.m. "Allergic Mechanisms," Lawrence Lichenstein, M.D., Associate Professor of Medicine, Johns Hopkins Medical School

9:15 a.m. "Breathing Problems After Cosmetic Surgery," Harold Deutsch, M.D.

9:45 a.m. Coffee Break

9:55 a.m. "The Otolaryngologic Approach to Vasomotor Rhinitis," Herbert Silverstein, M.D., Sarasota

10:15 a.m. Panel on "Allergic and Surgical Management of Nasal Polyps"
Moderator: George T. Singleton, M.D., Gainesville
Otolaryngologists: Bernard M. Barrett, M.D., Pensacola
Hueston C. King, M.D., Coral Gables
Allergists: Richard F. Lockey, M.D., Tampa
Angelo P. Spoto Jr., M.D., Lakeland

10:45 a.m. Panel on "T & A on the Allergic Child"
Moderator: J. Ryan Chandler, M.D., Miami
Otolaryngologists: W. Darby Glenn, M.D., Coral Gables
James V. Redd, M.D., Pompano Beach
Allergists: Meyer B. Marks, M.D., Miami Beach
Lawrence Lichenstein, M.D.

11:15 a.m. Panel discussion on "Allergic Aspects of Serous Otitis Media"
Moderator: Heinz J. Wittig, M.D., Gainesville

Otolaryngologists: John H. Webb, Jr., M.D., Orlando
Frederick D. Droege, M.D., Sarasota

Allergists: Paul F. Wubbena Jr., M.D., Jacksonville
Tillinghast G. Lybass, M.D., West Palm Beach

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)
Saturday, May 11
Regency Room East
Gerald Weinstein, M.D., Miami
Program Chairman

8:30 a.m. Resident Research Report

9:00 a.m. "Selected Topics Relating to Acne, Its Pathogenesis and Treatment," John Strauss, M.D., Professor of Dermatology, Boston University School of Medicine, Boston

10:00 a.m. Coffee Break

10:15 a.m. Research Reports

10:40 a.m. Acne Reports—John Strauss, M.D., Boston

11:30 a.m. Additional Research Reports

SECTION ON ISCHEMIC HEART DISEASE

(Co-sponsored by Florida Heart Association)
Saturday, May 11
Las Ambassadeurs
Dining Room
"Ischemic Heart Disease: Current Concepts for the Practicing Physician"
Robert D. Bloodwell, M.D., Orlando
Moderator

9:05 a.m. "Angina Pectoris in All Its Guises," Eugene Gross, M.D., Orlando

9:25 a.m. "Clinical Recognition of Coronary Disease: Value and Limitation of ECG Studies," Michael S. Gordon, M.D., Miami

9:45 a.m. "Exercise: ECG Stress Testing and Exercise Prescriptions," Zeb Burton, M.D., Orlando

10:05 a.m. Break

10:30 a.m. "Pathophysiology of Coronary Artery Disease: Occlusion Versus Stenosis Resulting in Cardiac Infarction," William C. Roberts, M.D., Bethesda, Maryland
or
Jack L. Titus, M.D., Houston, Texas

10:50 a.m. "Coronary Angiography and Evaluation of Ventricular Function," Sheldon Sbar, M.D., Tampa

11:20 a.m. "Coronary Bypass Grafts: Direct Internal Mammary to Coronary Anastomosis," Meredith L. Scott, M.D., Orlando, and Robert D. Bloodwell, M.D., Orlando

11:40 a.m. "Prognosis of Patients with Coronary Atherosclerosis: Coronary Risk Profile," Arthur J. Gosselin, M.D., Miami
or
James L. Mason, M.D., St. Petersburg
or
J. Curtis Williams, M.D., Pensacola

12:00 noon Adjournment

SECTION ON OBSTETRICS AND GYNECOLOGY

Saturday, May 11
Delegate Room
William T. Patton, M.D., Pensacola
Program Chairman

10:00 a.m. Case Reports and Scientific Papers

10:00 a.m. "The Effect of Dramamine on Uterine Contractility"
Bruce Shephard, M.D., Miami

10:15 a.m. "Diabetes Insipidus in Pregnancy"
Bo H. Bagenholm, M.D., Pensacola

10:30 a.m. "Leprosy in Pregnancy"
Luis Fernandez-Rocha, M.D. and Paul A. Gluck, M.D., Miami

10:45 a.m. Coffee Break

11:00 a.m. "Reversal of Scopolamine Effects with Physostigmine in Obstetrics"
David Mobley, M.D., Tampa

11:15 a.m. "Hemangioma of the Placenta Associated with a Neonatal Death"
Larry DeAngelo, M.D., Tampa

11:45 a.m. "Endometrial Carcinoma Nine Years Following Pelvic Irradiation for Carcinoma of the Cervix"
Armando Gutierrez, M.D., Tampa

SECTION ON PEDIATRICS

(Co-sponsored by Florida Pediatric Society)
Saturday, May 11
Regency Room South
George A. Richards, M.D., Gainesville
Program Chairman

Session I Moderator: Edward J. Saltzman, M.D., Hollywood

9:00 a.m "Current Concepts in the Management of Childhood Tumors," Judson G. Randolph, M.D., Surgeon-in-Chief, Children's Hospital National Medical Center; Professor of Surgery, George Washington University, and Chairman, Surgical Section, American Academy of Pediatrics, Washington, D. C.

9:20 a.m. Discussion

9:30 a.m. "Development Delays," Colin J. Condron, M.D., Director of Pediatrics, Orange Memorial Hospital, Orlando

9:50 a.m. Discussion

10:00 a.m. "Fever in the Pediatric Patient," Robert B. Lawson, M.D., Chief of Pediatrics, Variety Children's Hospital, Miami

10:20 a.m. Discussion

10:30 a.m. Break

Session II Moderator: John C. Moore Jr., M.D., Past President, Florida Pediatric Society, and Chairman, Children's Medical Renal Advisory Committee to the Department of Health and Rehabilitative Services, Lakeland

10:45 a.m. "Recent Clinical Studies of Human Growth Hormone," Allen W. Root, M.D., Professor of Pediatrics, All Children's Hospital, University of South Florida College of Medicine, Tampa

11:05 a.m. Discussion

11:15 a.m. "Enuresis," Jay M. Whitworth, M.D., Assistant Professor of Pediatrics, University Hospital of Jacksonville, University of Florida College of Medicine, Jacksonville

11:35 a.m. Discussion

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)
Saturday, May 11

Seminar Room #1
Arthur J. Pasach, M.D., Tampa
Program Chairman

10:00 a.m. "The Use of Orthetic Devices in Rheumatoid Arthritis Involving the Upper Extremities," Robert L. Bennett, M.D., Director of Professional Education and Research, Warm Springs Foundation, Warm Springs, Georgia

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society of Preventive Medicine)
Saturday, May 11
Secretariat Room
Marshall E. Groover, M.D., Fernandina Beach
Program Chairman

9:30 a.m. "Risk Factors and Heart Attacks and Stroke," A. F. Ullman, M.D., Panama City

9:45 a.m. "Early Detection of Risk Factors," William Cox, M.D., Daytona Beach

10:00 a.m. "The Community Control of Hypertension," William G. Simpson, M.D., DeFuniak Springs

10:15 a.m. "The Prevention of Thrombotic Complications (Low Dose Heparin)," Edwin Boyle, M.D., Miami

10:30 a.m. "Exercise and the Prevention of Coronary Disease," P. Edward Dodge Jr., M.D., Inverness

10:45 a.m. Panel Discussion

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Proctologic Society)
Saturday, May 11
Tack Room
Emmett F. Ferguson, M.D., Jacksonville
Program Chairman

9:00 a.m. "Closed Hemorrhoidectomy," W. Patrick Mazier, M.D., Ferguson Clinic, Grand Rapids, Michigan

9:20 a.m. "Cloacogenic Carcinomas and Neoplasias at and Near the Anorectal Line," Mathew Larkin, M.D., and Manuel L. Carbonell, M.D., University of Miami School of Medicine, Miami

9:30 a.m. "The Pathologist Looks at Inflammatory Disease of the Bowel," Ronald Rhatigan, M.D., Head of the Department of Pathology, University Hospital, Jacksonville

9:45 a.m. "Colonoscopy in Private Practice," Shed Roberson, M.D., Daytona Beach

10:00 a.m. Recess

10:15 a.m. "Anterior Resection Use of the Stapler," Emmett F. Ferguson, M.D., and Harold C. Houston, M.D., JHEP of the University of Florida College of Medicine, Jacksonville

10:30 a.m. "Carcinoma of the Colon, Rectum and Anus," W. Patrick Mazier, M.D., Grand Rapids, Michigan

11:00 a.m. Panel discussion

SECTION ON SURGERY

(Co-sponsored by Florida Chapter, American College of Surgeons and Florida Association of General Surgeons)
Saturday, May 11
Regency Room North
Nelson H. Kraeft, M.D., Tallahassee and
George H. Welch, M.D., St. Petersburg
Program Co-Chairmen
"Fiberoptics in Surgery"

9:00 a.m. "Bronchoscopy," Frederick H. Taylor, M.D., President-Elect, Southern Thoracic Association, Charlotte, N. C.

9:20 a.m. "Colonoscopy," John P. Christy, M.D., Miami

9:40 a.m. "Peritoneoscopy," Jeffrey B. Raskin, M.D., Miami

10:00 a.m. "Duodenoscopy," Jack A. Vennes, M.D., Minneapolis, Minn.

10:20 a.m. Panel Discussion

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic Surgeons)
Friday, May 10
Card Room
DeWitt C. Daughtry, M.D., Miami
Program Chairman

2:00 p.m. "The Management of Thoraco-Abdominal Aneurysms," Stanley Crawford, M.D., Professor of Surgery, Baylor University Medical Center, Houston, Texas
"Carotid Artery Surgery"
Panel—Dr. Crawford
Richard H. Blank, M.D., Tampa
John P. Collins, M.D., Lakeland
Francis N. Cooke, M.D., Miami

SECTION ON PEDIATRIC SURGERY

(Co-sponsored by Florida Association of Pediatric Surgeons)
Saturday, May 11
Delegate Room
James L. Talbert, M.D., Gainesville
Program Chairman

12:30 p.m. "Difficult and Unusual Problems in the Management of Wilm's Tumor," Judson G. Randolph, M.D. Surgeon-in-Chief, Children's Hospital National Medical Center; Professor of Surgery, George Washington University; and Chairman, Surgical Section, American Academy of Pediatrics, Washington, D. C.

12:50 p.m. "Mechanical Devices for Control of Incontinence," Orvar Swenson, M.D., Professor of Surgery, Division of Pediatric Surgery, University of Miami School of Medicine, Miami

1:10 p.m. "Parenteral Hyperalimentation," John H. Seashore, M.D., Assistant Professor of Surgery, Yale University School of Medicine, New Haven, Connecticut

1:30 p.m. "Management of the Child with Drainage from the Umbilicus," Albert H. Wilkinson Jr., M.D., Clinical Associate Professor of Surgery, University of Florida (Jacksonville Hospitals Educational Program), Jacksonville

1:45 p.m. "Omphalocele Repair," Jimmie E. Jones, M.D., Clinical Assistant Professor of Surgery, University of Florida (Pensacola Educational Program), Pensacola

2:00 p.m. "Malrotation of the Intestine," Ronald E. David, M.D., Pediatric Surgeon, Orlando

2:15 p.m. "Indication for Tracheostomy," William Brown, M.D., Chief of Surgery, Variety Children's Hospital; Instructor, Division of Pediatric Surgery, University of Miami School of Medicine, Miami

2:30 p.m. "Gram Negative Sepsis," Marc I. Rowe, M.D., Professor of Surgery and Pediatrics; Chief, Division of Pediatric Surgery, University of Miami School of Medicine, Miami

Scientific and Educational Exhibits

Convention Hall

1974

A-B "Scope of Plastic Surgery" — Florida Society of Plastic and Reconstructive Surgery.

C "A Treatment Program of Experimental Interaction" — Walter H. Wellborn Jr., M.D., Tarpon Springs.

D "The Imported Fire Ant: A Growing Problem for the Southern Allergist" — Robert B. Rhoades, M.D. and Richard Lockey, M.D., Gainesville.

E-F-G "Surgery for Dizziness" — Fredric W. Pullen, II, M.D. and Constance H. Cabeza, M.A., Miami.

H "Indications for Cardiac Catheterization" —James R. Jude, M.D., Irwin B. Boruchow, M.D. and Ramanuja Iyengar, M.D., Miami.

J "Pathophysiology and Treatment of Fat Embolus" — Edward J. Riseborough, M.D. and James H. Herndon, M.D., Boston, Mass.

K "Can You Nail the Diagnosis?" — Nardo Zaias, M.D. and Bernard Ackerman, M.D., Miami Beach.

L-M-N "Tympanomastoidectomy in 3-D: Revisions and Causes of Failure" — J. Brown Farrior, M.D. and James H. De Poyster, M.D., Tampa.

O "The Twentieth Medical Specialty: Family Practice" — Florida Academy of Family Physicians.

P "Papanicolaou Cancer Research Institute at Miami" — Jack Widrich, M.D., Miami.

Q "Bureau of Alcoholic Rehabilitation" — Helen Williams, M.D., Avon Park.

R "New Horizons: Better Health Through Better Understanding" — FMA Council on Voluntary Health Agencies.

S "Asthmatic Children's Foundation Residential Treatment Center" — Meyer B. Marks, M.D., Miami Beach.

T "Tuberculosis Control in Florida: Newest Techniques and Concepts" — Lawrence C. Manni, M.D., Jacksonville.

U "Vocational Rehabilitation and Two Disability Programs" — A. E. Ogden, M.D., Tallahassee.

V-W "Functions, Aims and Goals of the Florida Society of Rheumatology" — Florida Society of Rheumatology.

X-Y "The Florida Kidney Transplant Network" — Charles P. Hayes Jr., M.D. and James E. Fulghum, M.D., Jacksonville.

Z "A Pesticide Poisoning Investigation and Surveillance Unit" — John E. Davies, M.D., Miami.

AA "Diabetes Mellitis in Childhood and Adolescence" — Milton S. Grossman, M.D., Arlan L. Rosenbloom, M.D. and John I. Malone, M.D., Gainesville.

BB-CC "Coronary Artery Reconstruction Without Cardio-Pulmonary Bypass: Experimental" — Banning G. Lary, M.D., Roger W. Sherman, M.D. and Frank Gollan, M.D., Miami.

DD "Extracranial Cerebrovascular Disease" — Ian M. Reiss, M.D. and Melvin Levinson, M.D., South Miami.

EE "Results with Colonoscopic Polypectomy" — John P. Christie, M. D., Miami.

A Report on the FMA Professional Liability Insurance Plan

James W. Walker, M.D. and Gordon T. Hubbard

The availability and cost of professional liability insurance is of constant concern to all physicians in Florida. The Florida Medical Association was successful in obtaining a long-term contract (5 years) with the Argonaut Insurance Company to provide this coverage for physicians in Florida when notified that the previous carrier for 10 years would no longer continue the program.

The experience for the Argonaut Insurance Company in 1973 was not good with a total of 219 incidents reported during the year. Reserves had been established as of December 31, 1973 of $2,853,902. This is particularly alarming since past experience has proven that only 30 per cent of the claims to be expected for the contract year were reported in the first year. In January of 1974, there were 33 incidents reported to the Argonaut with 31 of these occurring in 1973.

We are confident that as a result of the close involvement of the Florida Medical Association and its component county medical societies in reviewing new applications, claims and overall administration of the program a downward trend in claims and premiums will be forthcoming in the future. The Florida Medical Association retains Medical Counsel to also assist the Argonaut Insurance Company in underwriting and claims review. The Argonaut Insurance Company maintains centralized claims coordination and all claims that are deemed non-meritorious by the company and the FMA are vigorously contested. All legal counsel is coordinated by the firm of Marks, Gray, Conroy & Gibbs of Jacksonville. We also will receive benefit from educational programs to be conducted by the Argonaut Insurance Company.

As part of their commitment to provide educational material, the Argonaut Insurance Company has announced the inauguration of a Medical Alert Communications (MAC) Program. The MAC Bulletin series will be divided into separate sections with Medicine, Nursing, Technology, Administration, Law, a General Comment Section and MAC Alerts. The MAC Alerts will have high priority bulletins warning of potential hazards in medical treatment, drugs or instrumentation. Guidance and technical direction for the MAC Program will be provided by an editorial board comprised of some of the nations foremost authorities in medicine, law and hospital administration.

This is the first publication of this kind produced by the Insurance Industry, and is a forerunner of other education and loss prevention materials that will be made available to participants in the FMA Liability Insurance Plan.

The following information was prepared to show the specialities and areas that resulted in incidents reported to the Argonaut Insurance Company last year.

Renewals issued 1-1-74

Individual	4,462	P.A.	480

Claim Incidents Per Insured Specialty

MEDICAL SPECIALTY		NO. CLAIMS	MEDICAL SPECIALTY		NO. CLAIMS
AN	Anesthesiology	23	PM	Physical Medicine & Rehab.	1
CD	Cardiovascular Diseases	2	R	Radiology	12
D	Dermatology	5	CRS	Surgery, Colon & Rectal	1
FP	Family Practice	4	GS	Surgery, General	31
GP	General Practice	33	NS	Surgery, Neurological	3
IM	Internal Medicine	26	ORS	Surgery, Orthopedic	19
OBG	Obstetrics & Gynecology	20	PS	Surgery, Plastic	4
OM	Occupational Medicine	1	TS	Surgery, Thoracic	5
OPH	Ophthalmology	3	TRS	Surgery, Traumatic	1
OTO	Otorhinolaryngology	7	U	Surgery, Urological	3
PTH	Pathology	1	OS	Other	2
PD	Pediatrics	9	PA	Professional Assn	2
P	Psychiatry	1			
				(25 Specialities) Total	219

Dr. Walker is Secretary-Treasurer of the Florida Medical Association. Mr. Hubbard is Director of the FMA Members Insurance Department.

Causes of Malpractice Claims—Codes

Code No.		No. of Incidents Reported
01	Foreign body left in patient during surgery	7
02	Improper treatment of fractures	3
03	Technical surgical error	37
04	Lack of informed consent	0
05	Error of an employee	2
06	Adverse reaction to drugs	17
07	Abandonment	4
08	Injury from equipment—including x-ray	5
09	Improper anesthesiology	20
10	Tooth damage during anesthesia	7
11	Improper diagnosis or treatment—not involving surgery	41
12	Injury from falls during examination	8
13	Disfigurement from surgery	6
14	Infection in surgical site	3
15	Personal Injury (libel, slander, etc.)	1
16	Injury to mother in childbirth	1
17	Injury to child in childbirth	9
18	Assault (generally operating without prior permission)	2
19	Contractual (not getting result promised the patient)	3
20	All other	39
21	Injuries or infections from blood transfusions	3

Age Groups	Number of Incidents
30-40	77
41-50	79
51-60	45
61-65	10
Over 65	6
P.A.	2
	219

NO PRIOR CLAIMS:	151
PRIOR CLAIMS:	66
FOREIGN MEDICAL GRADUATES	31

INTERNSHIPS		
Approved:	214	
Not Approved:	3	
RESIDENCIES		
Approved	192	
Not Approved:	25	
BOARD CERTIFIED:		116
BOARD QUALIFIED:		43
NEITHER BOARD CERTIFIED OR QUALIFIED:		58

TYPE OF PRACTICE	
Solo	88
Solo Professional Assn.	14
Professional Assn.	90
Partnership	12
Employed	12
Corporation	3
Total	219

CLAIM INCIDENTS PER MEDICAL DISTRICT

DISTRICT A (North Medical)

County Medical Society	No. Claims
Alachua	2
Bay	1
Capital	2
Clay	1
Columbia	2
Duval	17
Escambia	2
Franklin-Gulf	1
Okaloosa	1
Panhandle	1
Putnam	3
St. Johns (Flagler)	2
Total	35

DISTRICT B (West Medical)

Charlotte	1
Highlands	3
Hillsborough	15
Lake	1
Lee	2
Manatee	4
Pinellas	14
Polk	8
Sarasota	3
Total	51

DISTRICT C—(East Medical)

Brevard	6
Broward	33
Indian River	4
Orange	21
Palm Beach-Hendry	9
St. Lucie	2
Seminole	7
Volusia	1
Total	83

DISTRICT D (South Medical)

Dade	49
Monroe	1
Total	50

Total incidents reported through December 31, 1973: 219

What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.

Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

Sequence of therapy— selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

ROCHE

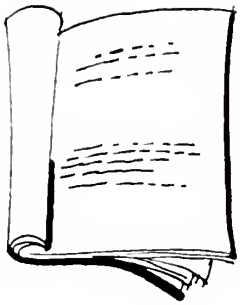
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

This patient's lesions were resolved with

Efudex®

fluorouracil/Roche®

5% cream/solution...a Roche exclusive



Others Are Saying

Generics—A New Monster?

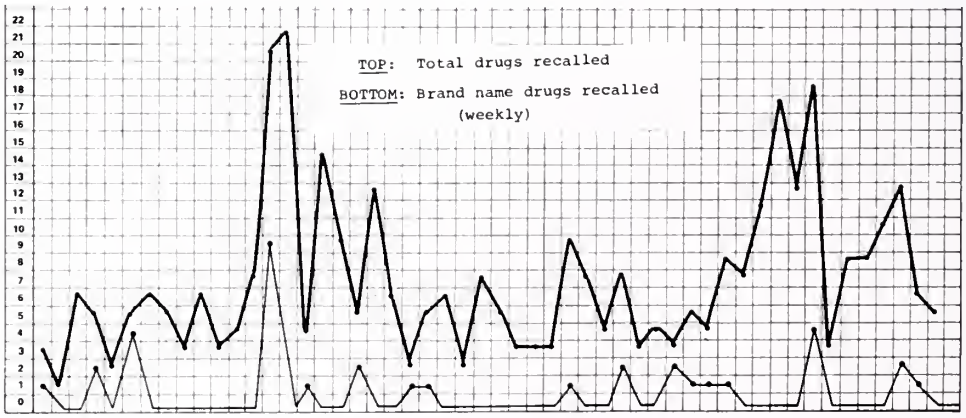
In June, 1973, your editor, in *Miami Medicine,* wrote an article protesting an FDA action which would compel us not to use combination drugs. An example was given of a simple cough syrup which cost $2.00 for four ounces. The new proposal would now cost $9.00—a net loss to the consumer of $7.00, not to mention the time and paperwork on writing the prescription.

We are now faced with a new FDA edict and a repeal of the antisubstitution law in Florida, called the Forbes Bill, or HB 2279. Representative John Forbes (Dem-Duval) has proposed that the Board of Pharmacy establish a formulary of brand names of drugs and pharmaceuticals with their generic equivalents. It requires the pharmacy to post a sign which reads:

"Upon request, this pharmacy may be able to substitute a less expensive though equally effective medicine than the one prescribed by your doctor."

Why should we be opposed to HB 2279? There are reasons too numerous to mention—but to mention a few: The recall rate of non-brand name drugs is many times higher than that of brand names (see chart). For example, various brands of oxytetracycline, although batch certified by FDA, were found unable to reach therapeutic levels in man. Over 11,000 tubes of ophthalmic penicillin ointment had to be recalled because of contaminated metal particles; 3,700 vials of progesterone were recalled with potency ranging from 55% to 101% of the declared amount. Over 600,000 digitoxin tablets ranging from 79% to 197% of the labeled claim were recalled.

Even the FDA concurs that an equivalent drug which satisfies chemical and other analytical tests of equivalence, may not be therapeutically equivalent because of each drug's difference in bioavailability.



Why is the FMA generally opposed to HB 2279? To quote:

1. If this law is enacted the physician will still maintain liability for untoward results from a drug that is substituted for his original prescription.

2. There is no documentation that this bill would result in cost savings to the consumer. In fact it will likely result in higher profits for unethical pharmacists. Antisubstitution laws were enacted as consumer protection measures to prevent the substitution abuses by some pharmacists.

3. Therapeutic equivalency of chemically equivalent drug products cannot be assured today, nor is it likely to be done on a broad scale in the near future.

4. Florida's existing antisubstitution laws do not prevent the ethical pharmacist from consulting with the physician, suggesting alternate drug products for good reason, or helping keep the physician alerted as to newer and important information on the drug product prescribed.

5. Present law does not prevent the physician from prescribing the least expensive drug that will accomplish the desired patient results.

All physicians who are concerned with this problem are urged to take time now and write to the members of the Business Regulation Committee indicating opposition to HB 2279. Telephone contact is also suggested where appropriate.

As your editor stated in June 1973—What the consumer needs is protection from his protector.

EDWARD W. ST. MARY, M.D., *Editor*
MIAMI MEDICINE

Reprinted from the Editorial Page, Miami Medicine, February 1974.

Have You Seen This Boy?

The Hillsborough County Sheriff's Office has asked for the cooperation of *The Journal* in its investigation of the disappearance of Matthew Alred, age 3 (picture above). The child was last seen between 5:15 and 5:30 p.m. on Sunday, January 27, 1974, in the backyard at his home, 2601 South 68th Street, Tampa. When last seen, he was wearing a white "T" shirt, light blue cut off jeans, and brown suede pointed cowboy boots.

Authorities believe the child may have been abducted by someone who wanted a child of his own. If this is the case, he may be taken to a doctor's office or other medical facility in due course.

Description: White male, 3 years old (born May 26, 1970), 3 feet three inches in height, weight 40 pounds. Blonde hair, blue eyes, chip on lower left front tooth.

Anyone with information as to the whereabouts of this child is asked to call the Hillsborough County Sheriff's Office immediately. Tel. (813) 228-7311.

Florida Allergy Society Has 25th Anniversary

In 1949 a small group of Florida physicians with a special interest in allergy met at Belleair and founded the Florida Allergy Society. The membership has grown and this year they celebrate its 25th anniversary. Dr. Albert M. Ziffer of Altamonte Springs serves as president, Dr. Angelo P. Spoto Jr. of Lakeland as president-elect, and Dr. Gerard F. Carter of Miami as secretary-treasurer.

Charter members included Drs. Solomon D. Koltz and Clarence Bernstein of Orlando; Drs. M. Jay Flipse, Edwin P. Preston, James H. Putnam and Harold Rand of Miami; Dr. G. Frederick Hieber of St. Petersburg; Dr. Frank Metzger of Tampa; Drs. L. Paley and Nelson Zivitz of Miami Beach; Dr. J. M. McDonald of Jacksonville; Dr. Fred D. Droege of Sarasota, and Dr. M. Gardner of West Palm Beach.

Some of this country's outstanding allergists make up the Society: Dr. Samuel C. Bukantz of Tampa, editor of Hospital Practice; Drs. Jack Rudolph and Meyer Marks of Miami Beach, authors of many books and articles; Dr. Morton L. Hammond of Miami, director of the Adult Allergy Clinic at Jackson Memorial Hospital; Dr. Quintero, an honorary member of seven foreign allergy societies; Dr. Hieber, past president of the American College of Allergists; Dr. Robert Brennan of Ft. Lauderdale, president of the American Association for Clinical Immunology and Allergy; Dr. Heinz J. Wittig of Gainesville, chief of the Division of Pediatric Allergy at the University of Florida College of Medicine, and Dr. Zivitz, past president of the Dade County Medical Association.

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A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

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CATHERINE T. RAY, M.D.

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or

Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Any side reactions to Dimetapp Extentabs may include hypersensitivity reactions such as urticaria, leukopenia, agranulocytosis and thrombocytopenia, drowsiness, dizziness, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypertension, hypertension, headache, nervousness, dizziness, tremor, insomnia, nervous visual disturbances, mydriasis, CNS depressant and less often stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming)

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

"...a more satisfactory treatment..."[1]

VITAMIN C

MICRO-DIALYSIS SUSTAINED RELEASE

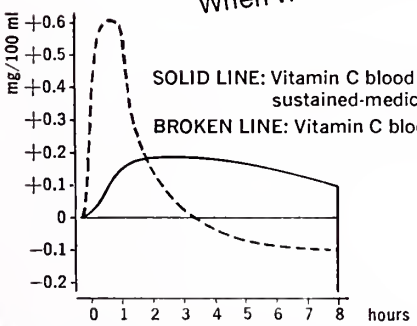
500 mg. CAPSULES

CEVI-BID

CEVI-BID Capsules permit convenient, b.i.d. dosage for more predictable, sustained vitamin C blood levels all day and night. This avoids the "peaks and valleys" that result from ordinary vitamin C intake (wasteful renal excretions at high levels and less than optimum amounts of vitamin C at low levels). The unpredictability of enteric-coated vitamin C is also avoided. Cevi-Bid's unique micro-dialysis principle provides release of 500 mg. of vitamin C during a 12 hour period at a smooth, uniform rate.

"This method [CEVI-BID] provides a more satisfactory treatment of disorders requiring administration of vitamin C in repeated doses of relatively small amounts."[1]

When vitamin C is indicated . . . prescribe CEVI-BID.



SOLID LINE: Vitamin C blood levels obtained with sustained-medication capsules (CEVI-BID).

BROKEN LINE: Vitamin C blood levels obtained with tablets.

*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

Samples on Request

GERIATRIC PHARMACEUTICAL CORP.

Floral Park, N.Y. 11001

Pioneers in Geriatric Research

[1] Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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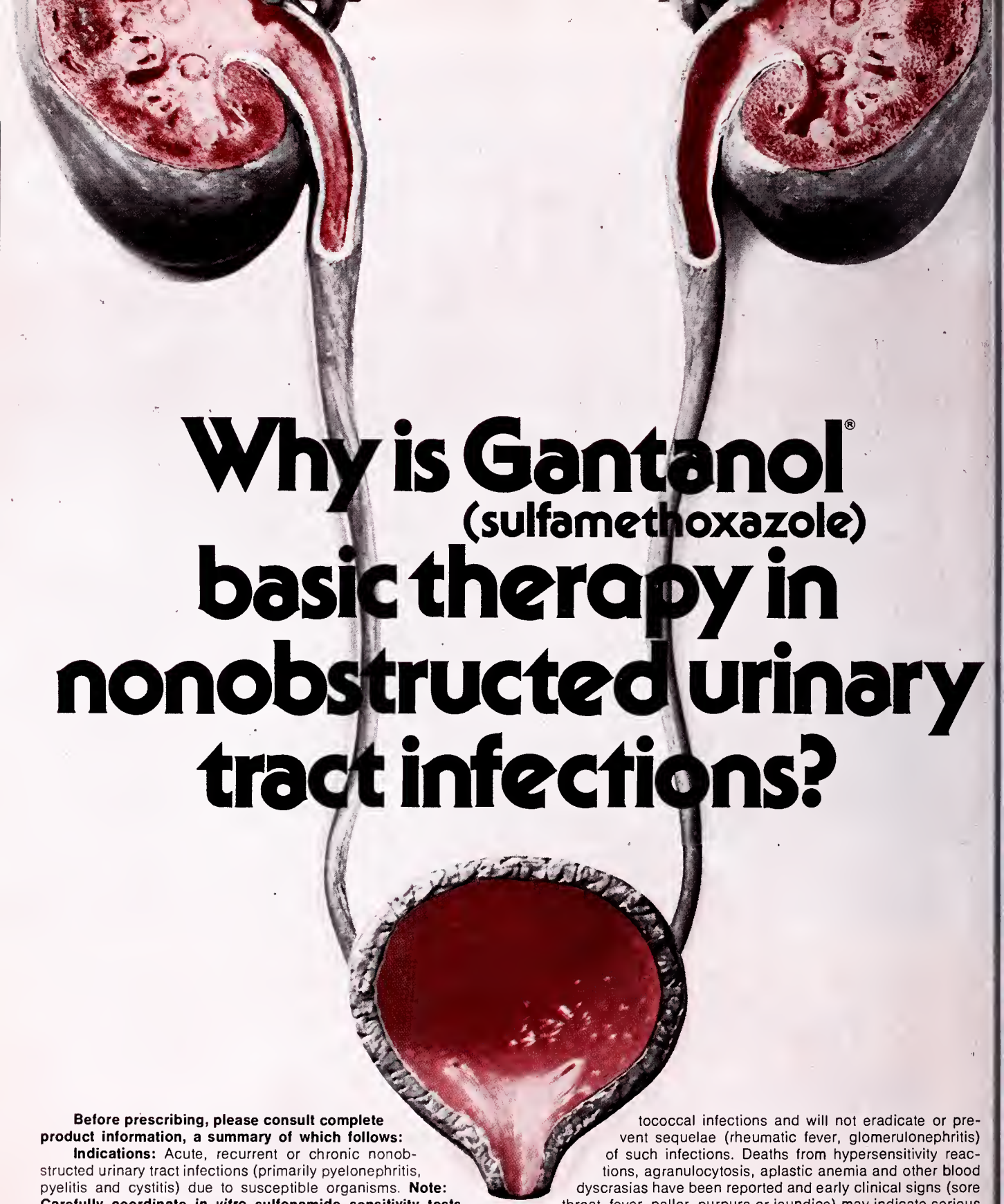

Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
- for control of *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*
- for prompt antibacterial blood and urine levels in from 2 to 3 hours after initial 2-gram adult dose
- for economical around-the-clock coverage
- for maximum patient cooperation with easy-to-remember B.I.D./T.I.D. dosage

Basic Therapy

Gantanol®

(sulfamethoxazole)

Tablets/Suspension
(0.5 Gm) (0.5 Gm/teasp.)

pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Letters

To the Editor: New threats to the prescribing freedom of the physician and to the quality of the nation's drug supply have surfaced in a new proposal of the Department of Health, Education, and Welfare.

The medical profession should be widely alerted to this newest suggested encroachment on the operations of our health care system. Quite bluntly, we believe that state medical societies should be better informed and more concerned over the proposal, which was announced by HEW Secretary Weinberger on December 19, 1973, in testimony before the Health Subcommittee of the Senate Committee on Labor and Public Welfare. He said at that time that the Department planned to issue regulations to limit drug reimbursements under Medicare and Medicaid "to the lowest cost at which the drug is generally available unless there is a demonstrated difference in therapeutic effect." The proposal is based on the unsupportable premise that the Food and Drug Administration can assure the uniform quality, efficacy and equivalency of all marketed drugs.

The facts are (1) that all drug products are not of equal quality; and (2) the FDA is in no position now, or in the foreseeable future, to assure their effectiveness or equivalency. Evidence as to the unequal performance of drug producers can be seen in a dramatic way from the records of the Department of Defense. For the period 1962 through 1971, the Military Defense Supply Agency, the world's largest single purchaser of pharmaceuticals, rejected 42 percent of drug product samples and gave failing marks to 45 percent of the production facilities inspected.

The scientific literature contains many reports showing a lack of therapeutic equivalency among generic drugs, many of them widely prescribed.

The issue, however, is not one of brand-name versus generic drugs. The issue is quality and source. The physician particularly is put in an unfair position. Only he knows which drug products have performed satisfactorily for his patients. What does he do, then, when he wants to prescribe a product more costly than the "lowest" priced one specified as reimbursable by the government? It would appear that the patient would have to bear the additional cost—which could mean a real hardship for the aged and welfare patients . . .

The medical profession should resist this unwise and impractical proposal.

C. Joseph Stetler, President
Pharmaceuticals Manufacturers Assn.
Washington, D. C.

Editor's Note: The following letter to the members of the Orange County Medical Society was forwarded to the Journal by Bob Zellner with the opinion that it would be of interest to all physicians in Florida—with this, the Journal concurs.

Dear Colleague:

If you are at your office during busy hours of the morning—

DON'T READ THIS NOW

Fold it up and put it in your hip pocket and read it after lunch in the hospital dining room or at home tonight.

Manuel Coto might say, "Sheep don't make a revolution." I want your personal support because I want you to join with me in the FPA-Florida Physicians Association.

C.C.: Anticipated confrontations with State and Federal Agencies on Private Practice Concepts.

Past Hx: During the past ten years I have been many times consecutively your elected delegate to FMA, your Secretary, President, Chairman of the Executive Committee, and am now your Chairman of the Board of Censors. That adds up to a lot of exposure to politics of medicine and political politics that affect medicine. Medicare, Medicredit, HR 10, HMO, CHP, PSRO, etc. And all this developing in a country with what I believe has unequaled medical care in the world—

transplant and bypass surgery, super cardiac monitoring, ICU, CCU, Chemo Rx, nuclear and ultrasound medicine, etc.

Family History: Audrey and I have visited England, Portugal, Spain, West Germany, France and in November of last year—Russia. I have specifically attempted to evaluate hospitals, x-ray departments, x-ray equipment, medical schools, consumer medical care and patient's satisfaction in each of these countries. I know that the people of U.S.A. have it best over all.

In London, one of their physiotherapy departments was supersuperb, out of Lisbon I went through a most outstanding prosthetic limb factory, the hospital of the Iron Gate in Madrid has the world's best bacteriological infection control, CGR neurological x-ray equipment in Paris is tops, Siemans makes exquisite x-ray mammogram generators, and Russia. . . . .well, the student nurses are lovely.

In Russia, I believe that if a newborn can't breathe and survive on his own after two hours, that's it. People in rural Spain don't go to a doctor or hospital "til it's time to die." English hernias have 26 months waiting. For the people in these foreign countries it's all they ever knew and their governments tell them health will be better next year or the next.

Social History: 1965 Medicare to 1973 PSRO. Canadian medicine takeover several years ago. N. Y. Times, Washington Post, Cohen, Senator Ted Kennedy, Unions, the late Walter Reuther, Liberal Democrats, TV.

Complications Possible:

1. 1975 Kennedy type bill with Social Security type administration of all health care.
2. Other undesirable national health legislation.
3. More and more regulations like preadmission panels, frozen fees, etc.

Dx: Health Care delivery and related legislature will continue to change—sometimes good and sometimes bad. No doubt the near future will bring required postgraduate training, retesting and recertification, government support of catastrophic coverage, more support to poor and aged, and some form of peer review and cost accounting. BUT doctors in the form of organized medicine should be in on new laws and regulations, guiding their directions and their effects. All we doctors believe that *quality medicine* can only be practiced when the doctor is free to do what he knows is best for his patient.

Rx:
1. If you want to get involved personally with your future, talk to Norman Coulter, Duncan McEwan, Charles Collins, Joe Matthews, Lou Murray, Bob Zellner, Frank McKechnie, Byron Thames, Jack Jowett, Charles Grant, Dean Steward, etc.
2. If you would rather golf, tennis, travel, etc., I believe you cannot afford not to support those of us who do want to personally fight for private practice. So . . . you can join and pay dues to the AMA, FMA, Flampac, Ampac, and now. . . . FPA.

Your delegates to the FMA two years ago along with other representatives of medicine throughout the state voted to have an economic organization to buffer Florida doctors in statewide bargaining with third parties. The President then appointed Jim Cook of Marianna, (Internist), Jack MaCris of St. Pete, (Surgeon), Thad Moseley of Jacksonville, (Surgeon), and me from Orlando, (Radiologist), ...to design, incorporate and implement such an organization. We began over a year ago. It's the Florida Physicians Association, Inc. (FPA), legally incorporated, active officers, and so far 1,000 of our 9,000 doctors in Florida have joined in the past few months. I now want all of you in Orange County to join.

Why FPA over other much similar right-wing splinter groups? Because the FPA is to be the expendable arm of Florida organized medicine—hopefully, a buffer between government and private medicine. We would have all of the input of all of the members of FMA and Orange County Medical Society in terms of expertise, manpower source, etc. As we were starting this we spoke to the doctors in the Canadian Health Program and they felt that if they had had such an organization as FPA they would have fared infinitely better. We need near total membership in Florida for best effect. Private practice may be sinking—we may need a real confrontation in 1975, and I want the organization to which we belong to be able to act at a high level.

Prognosis: I am counting on your application and/or your personal involvement. We've got to win most of the battles and control the losses. "Sheep don't win a revolution."

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CANDEPTIN Vaginal Tablet Therapy Pack—28 vaginal tablets

Brief Summary

Description: CANDEPTIN (Candicidin) Vaginal Ointment contains a dispersion of Candicidin powder equivalent to 0.6 mg. per gm. or 0.06% Candicidin activity in U.S.P. petrolatum. 3 mg. of Candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candicidin powder equivalent to 3 mg. (0.3%) Candicidin activity dispersed in starch, lactose and magnesium stearate.

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Action: CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGELETTES Vaginal Capsules possess anti-monilial activity.

Indications: Vaginitis due to *Candida albicans* and other *Candida* species.

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Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETTES Vaginal Capsules have been extremely rare.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETTES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Available Dosage Forms: CANDEPTIN Vaginal Ointment is supplied in a Patient Therapy Pack, containing two 75 gm. tubes with two applicators for the full course of treatment. CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN Vagelettes Vaginal Capsules are packaged in a Patient Therapy Pack, containing 28 CANDEPTIN Vagelettes Vaginal Capsules (2 boxes of 14), for the full course of treatment. Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

References:

1. Melges, F. J.: Obstet. Gynecol. *24*:921, Dec. 1964. 2. Cameron, P. F.: Practitioner *202*:695, May 1969. 3. Olsen, J. R.: Journal-Lancet *85*: 287, July 1965. 4. Giorlando, S. W.: OB/GYN Digest *13*:32, Sept. 1971. 5. Decker, A.: Case Reports on file, Medical Department, Julius Schmid. 6. Friedel, H. J.: Md. State Med. J. *15*:36, Feb. 1966. 7. Roberts, C. L. and Sullivan, J. J.: Calif. Med. *103*:109, Aug. 1965. 8. Giorlando, S. W., Torres, J. F. and Muscillo, G.: Am. J. Obstet. Gynecol. *90*:370, Oct. 1, 1964. 9. Abruzzi, W. A.: Western Med. *5*:62, Feb. 1964.

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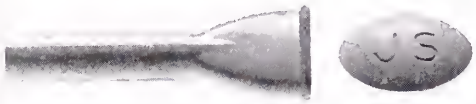

Vaginal Tablets

MEETINGS

Approved by FMA Committee on Continuing Education

APRIL

Biomechanics in Sports, April 2-5, Flagler Inn, Gainesville. For information: American Academy of Orthopedic Surgeons, 430 N. Michigan Ave., Chicago 60611

"Clinical Nephrology and Heart Disease II," April 3-5, Eden Roc Hotel, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140

Infertility & Human Reproduction, April 4, Diplomat Hotel, Miami. For information: American Fertility Soc., 1801-9th Ave., S. Birmingham, Ala. 35205

Postgraduate Seminar in Emergency Medicine, April 4-7, Playboy Plaza Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 1200 N.W. 10th Ave., Miami 33152

Anatomy of Infection, The Pathogenicity and Treatment of Common and Uncommon Pathogenes, April 5, A. Vance Morgan Educational Center, S. Miami Hospital, South Miami

Hypertension, April 8-9, Sheraton Four Ambassadors Hotel, Miami*

Ophthalmic Plastic and Corneal Surgery, April 8-12, Doral Hotel, Miami Beach*

Thirteenth Workshop in Electrocardiography for Physicians and Cardiac Nurses, April 18-22, Tides Hotel and Bath Club, Redington Beach. For information: Henry J. L. Marriott, M.D. St. Anthony's Hospital, St. Petersburg 33705

Practical Optics and Refraction, April 19-20, J. H. Miller Health Center, Gainesville**

▸ American Academy of Facial Plastic & Reconstructive Surgery, Inc., April 20-22, The Breakers Hotel, Palm Beach. For information: Carl N. Patterson, M.D., 1110 W. Main St., Durham, N. C. 27701

Postgraduate Seminar on Arthritis and Related Diseases, April 19-21, Thunderbird Motor Hotel, Jacksonville 32207

▸ American Otological Society, Inc., April 21-22, The Breakers Hotel, Palm Beach. For information: G. Dekle Taylor, M.D., Marshall Taylor Doctors Bldg., Jacksonville 32207

▸ American Neurotology Society, April 22, The Breakers Hotel, Palm Beach. For information: Sidney N. Busis, M.D., 3500-5th Ave., Pittsburgh, Pa. 15213

Courses of Instruction in Coronary Care for the Practicing Physician, April 22-27, University of Miami School of Medicine, Miami 33152*

▸ American Society for Head and Neck Surgery, April 23-24, The Breakers Hotel, Palm Beach. For information: William M. Trible, M.D., 1234-19th St., N.W., Washington, D. C. 20036

▸ American Laryngological, Rhinological & Otological Society, Inc., April 23-25, The Breakers Hotel, Palm Beach. For information: Louis E. Wilcox, M.D., 108-111 Lankenau Medical Bldg., Philadelphia, Pa. 19151

▸ American Broncho-Esophagological Association, April 25-26, The Breakers Hotel, Palm Beach. For information: Walter H Maloney, M.D., 2065 Adelbert Rd., Cleveland, Ohio 44106

Urology: Selected Topics for the Practitioner, April 25-27, Hilton Hotel, Gainesville**

American Industrial Health Conference, April 29-May 3, Americana Hotel, Miami Beach. For information: Industrial Medical Association, 150 N. Wacker Dr., Chicago 60606

▸ National meetings being held in Florida.

MAY

Master Approach to Cardiac Emergencies, May 2-4, Contemporary Hotel, Disney World, Orlando*

The Management of the Critically Ill Patient, May 3-4, Hilton Hotel, Gainesville**

An Intensive Day in Critical Care Medicine, May 4, Hilton Hotel, Gainesville**

Clinical Care of Bone Tumors, May 9-11, University of Florida, Gainesville**

Microneurosurgery, May 9-12, Innisbrook Resort & Gulf Club, Tarpon Springs**

Instruction Courses in Coronary Care for the Practicing Physician, May 13-18, University of Miami School of Medicine, Miami*

Acute Coronary Care, May 17-18, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

Respiratory Disease Physicians Seminar, May 19-20, Turtle Inn, Atlantic Beach. For information: Florida Lung Association, P. O. Box 8127, Jacksonville 32211

Instrumentation in Cardiology, May 24-26, Port O'Call Resort, St. Petersburg. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

JUNE

Eighth Annual Workshop in Electrocardiography, June 17-22, Sheraton Olympic Villas, Orlando. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

AUGUST

Postgraduate Obstetric-Pediatric Seminar, Aug. 15-17, Pier 66 Hotel, Fort Lauderdale. For information: A. F. Caraway, M.D., P.O. Box 210, Jacksonville 32201

SEPTEMBER

Teaching Conference in Radiology, Sept. 11-15, Doral Country Club, Miami*

By Arrangement In-Service Tutorials in Family Medicine; Neonatology; Oncology, Ophthalmology; Otolaryngology; Pediatric Cardiology; Radiology; Renal Disease, Hypertension and Renal Dialysis; Urology*

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By Arrangement Visiting Lecturers Program—a program designed to provide continuing education based on specific requests from local medical groups and hospitals*

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*For Information: Contact the Division of Continuing Education, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610.

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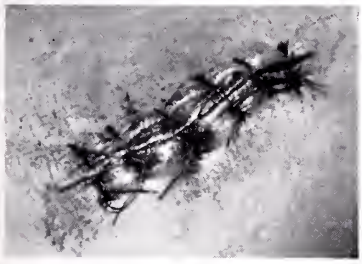

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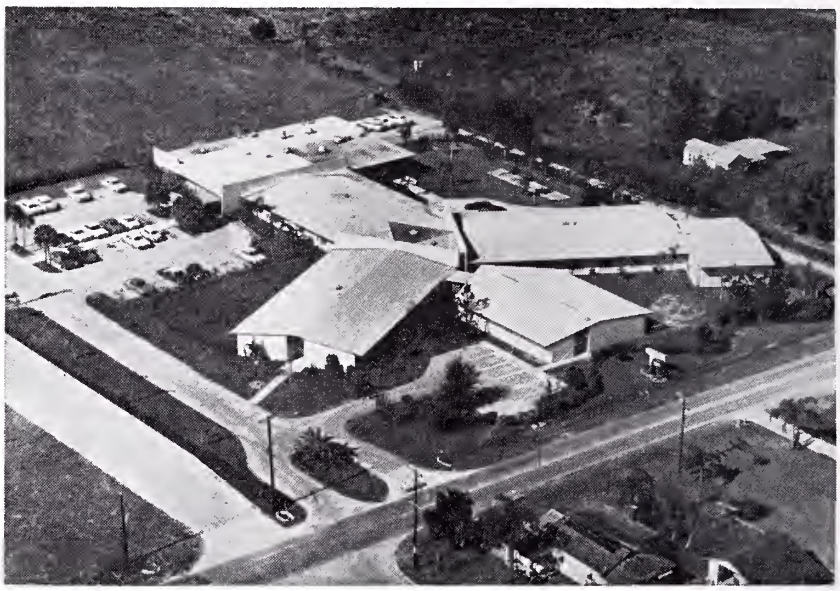

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INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

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MIAMI, FLORIDA AREA. Seven man multispecialty, fee-for-service group is seeking an internist to join the group. Generous first year profit guarantee. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

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FAMILY PRACTITIONER OR INTERNIST WANTED to join newly formed clinic in newly developed ITT community. Full or part time. Excellent opportunity for retired physician to supplement income. Financial arrangement flexible. Write or call: Jack Dunn, M.D., 4 Carol Court, Palm Coast, Flagler Beach, Florida 32036. Phone (904) 445-3868.

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1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

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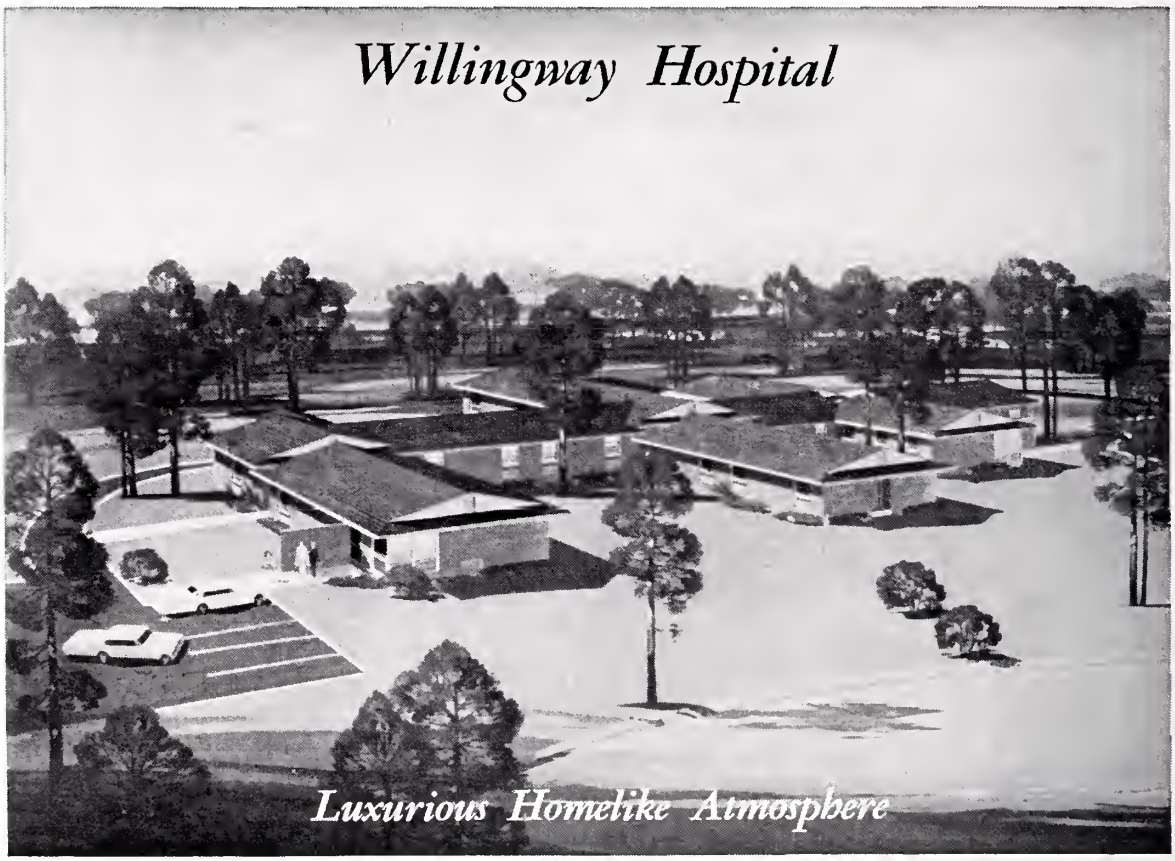

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Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

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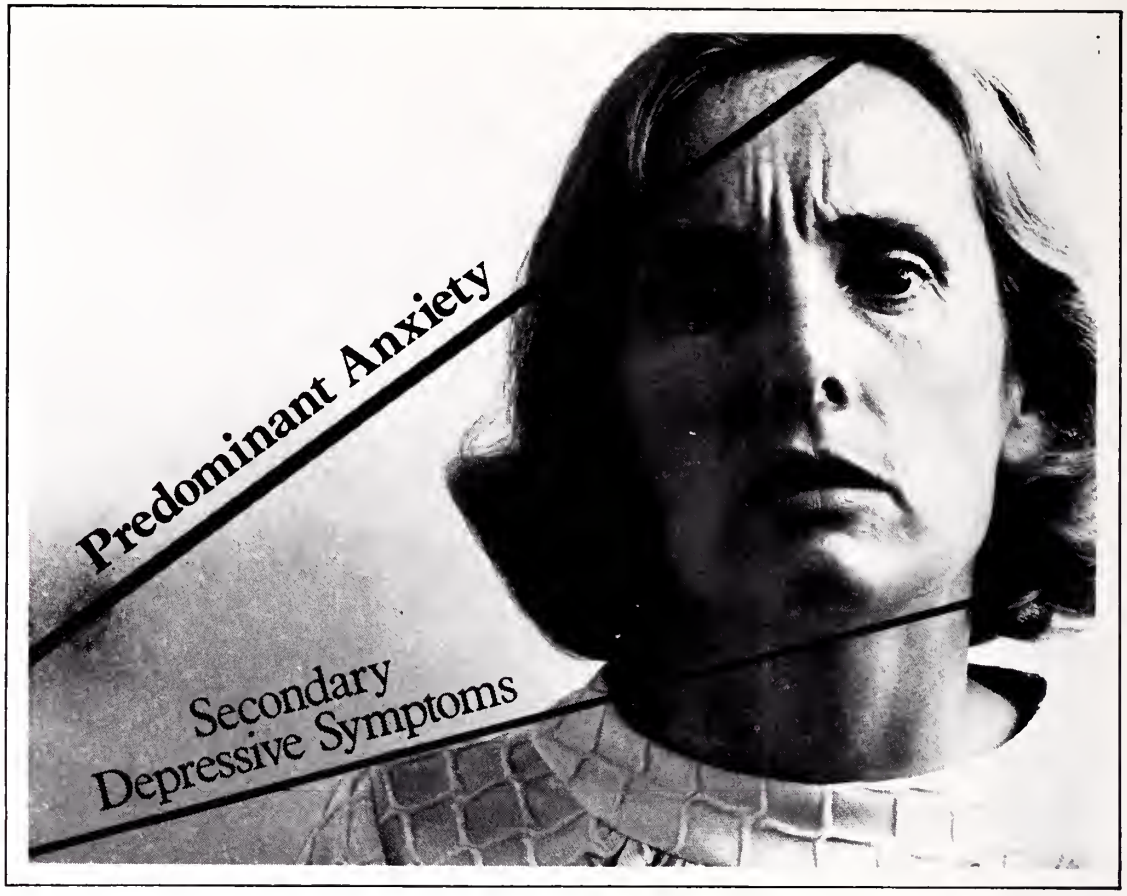

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MAY COVER—We are grateful to Neal A. Robinson, M.D. of Eustis, Florida for sending us the cover photo of a sunset taken in the Ding Darling Bird Sanctuary at Sanibel Island.

President's Page

I'm Sick of It!

Everyone seems to be a vocal "expert" on the medical profession these days! However, there are some unsaid things that need saying, and it appears that a doctor will have to step up and say them. Here goes:

I'm sick of those who attempt to degrade my profession with emphysematous wheeze and sarcastic reference about the dedicated physician. You're darned right I'm dedicated, and I got there the hard way; and further, I have no intention of changing.

I'm sick of the giveaway policy complicated by the tax-compensated legislator—the same "politician" who feels that we are incompetent to diagnose and treat the ills of a nation. Yet, by comparison, our track record is much better than his.

I'm sick of the pubescent punk, wallowing in self-pity, who vocally points with disrespect at the affluent physician as one who doesn't try to understand his problem. However, as a student, I too was an activist. If I weren't still an activist, I would not be involved in organized medicine or writing this editorial. Constructive criticism and responsible freedom I understand and respect. Our nation and profession were built on these premises. Attempts to degrade them are irresponsible, destructive rhetoric by the decerebrate professors, illiterate writers, and debasing TV medical specials that substitute sensationalism for merit. Our hypochondriac critics couldn't cut the mustard themselves, so they have found an avocation in the condemning of medicine.

I'm sick of the ostentatious verbiage about the "right of medical care" and its inadequacy. I believe every American has the same right to medical care as he does to food, clothing, shelter, and education. But, not for one moment do I mean to infer that they are inadequate, either. Should everyone be fed steak each night? Live in a palatial home? Attend one of the elite eastern universities? Then, why does everyone have the right to have his medical ills treated at the Ivory Tower? This is still the United States—not Russia. There still exists the matter of incentive. The material rewards and the available kidney machines still go to the productive.

And, while I'm at it, I'm sick of an expanding social order which is being built on all forms of permissiveness. My eighth grade graduating class includes ministers, doctors, farmers, carpenters, educators, and many fine mothers. Are these contributing citizens to be replaced by dropouts who are being allowed and actually urged to "do their own thing"?

If this editorial sounds like the swan song of a dying conservative establishmentarian, it isn't. It's an agitated activist's appeal for those who believe in our profession and are proud of the letters "M.D." This requires effort on our part to meet this challenge effectively. Wouldn't you like to join? 'Cause I'm sure you're sick of it too!

This editorial first appeared in the Summer, 1970 issue of Florida Family Physician. With minor editing, it still best expresses my thoughts and seemed most appropriate for my final President's Page. JvT

P.S.—And with my wife Jane's assistance—this whole ideology might just rub off on our Jim, Judy, John and Joan.

SPECIAL CENTENNIAL ACTIVITIES

100th Annual Meeting
Florida Medical Association
May 8-12, 1974, Hollywood

THURSDAY, May 9 —

Program on "Sex and Sexuality"
Featuring Masters and Johnson
5:30 P.M. — Regency Room North

FRIDAY, May 10—

"Abel S. Baldwin Lecture"
Hon. Otis R. Bowen, M.D.
Governor of Indiana
11:00 A.M. — Regency Room North

Auxiliary/FLAMPAC Luncheon
Marilyn Van Derbur Atler (Miss America 1958)
Guest Speaker
12:15 P.M. — Les Ambassadeurs Dining Room

PRESIDENT'S RECEPTION
6:00 P.M. — Poolside

CENTENNIAL BANQUET
7:00 P.M. Regency South and West
Featuring
Entertainment by the "New Directions"

Presentation of the A. H. Robins Award, the Certificate of Merit, The Certificate of Appreciation, and the Distinguished Layman Award

A Special Presentation on the History of the Florida Medical Association by Historian William M. Straight, M.D., and Mrs. Mary Ann Mathews, President of the Auxiliary

and finally . . .

Couples will Swing and Sway to the Music of
Sammy Kaye and his Orchestra
9:00 P.M. to 1:00 A.M.

SUNDAY, May 12—

Prayer Breakfast
John R. Schenken, M.D.
Omaha
7:30 A.M. — Cafe Cristal

HOUSE OF DELEGATES

The House of Delegates will convene for three sessions:

Wednesday (May 8) at 4:00 p.m. . . .

Saturday (May 11) at 3:00 p.m. . . .

Sunday (May 12) at 9:00 a.m. . . .

The General Session of the House will be held on Friday, May 10, at 11:00 a.m.

Reference Committees will meet on Thursday, May 9:

No.	I	Health and Education, Regency Room South 10:00 a.m.
No.	II	Public Policy, Congress Room 10:30 a.m.
No.	III	Finance and Administration, Regency Room North 11:00 a.m.
No.	IV	Legislation and Miscellaneous, Regency Room East 10:30 a.m.
No.	V	Medical Economics, Regency Room West 10:00 a.m.

SCIENTIFIC PROGRAM

An outstanding scientific program has been arranged. These scientific sections will be held beginning on Thursday afternoon and will run through Saturday. Please consult pages 302-307 of the April issue of *The Journal of the Florida Medical Association* for program details.

A special scientific program sponsored by the FMA Committee on Scientific Assemblies entitled, "A Seminar on Infectious Diseases and Antibiotics" will be held on Thursday, May 9, at 1:30 p.m. and Friday, May 10, at 8:05 a.m. in the Card Room. An informational handout regarding this program will be available at the FMA registration desk.

TOURNAMENTS: Golf, Fishing and Tennis tournaments are being held this year and arrangements are being made by Broward County Medical Association. Contact: William G. Stafford, Ex. Dir.: (305) 525-1595.

acute gonorrhea*

This patient
just received
an effective, private,
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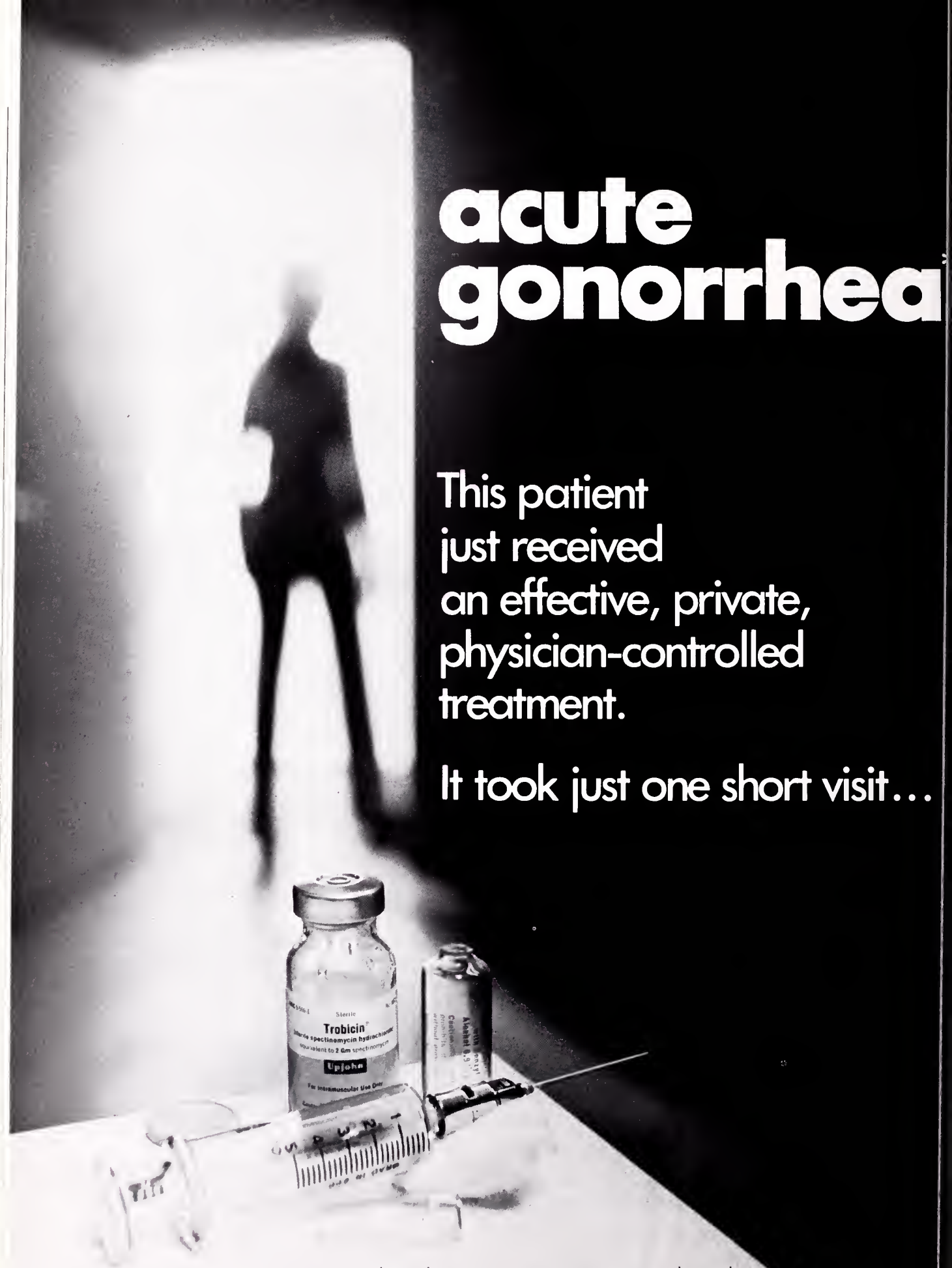
treatment.

It took just one short visit...



*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

'3 The Upjohn Company J-3437-6

Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED 8-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

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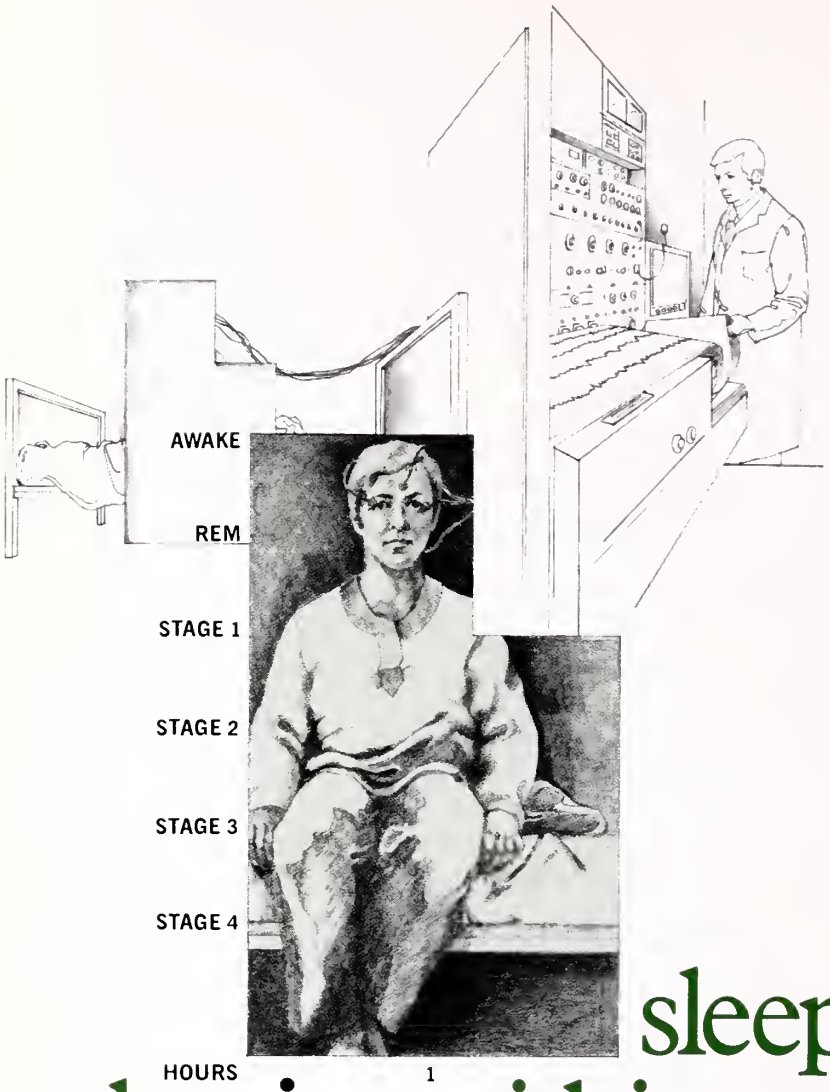
[methacycline HCl]

Delivers from the very first dose:

Studies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains are known to be resistant, routine sensitivity testing is recommended.



sleep begins within 17 minutes, on average ...

an initial benefit of

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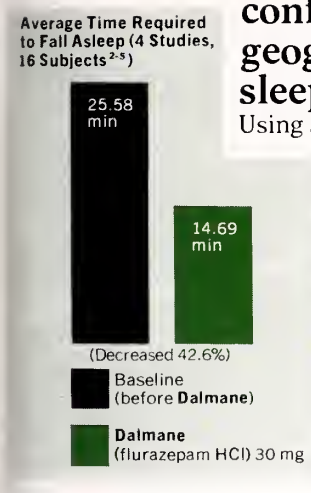
(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

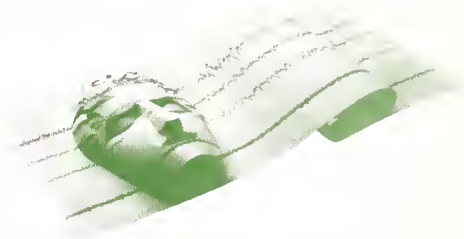
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
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One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

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Brief Summary

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Action: CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGELETTES Vaginal Capsules possess anti-monilial activity.

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Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

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Federal law prohibits dispensing without prescription.

References:

1. Melges, F. J.: Obstet. Gynecol. *24*:921, Dec. 1964. **2.** Cameron, P. F.: Practitioner *202*:695, May 1969. **3.** Olsen, J. R.: Journal-Lancet *85*: 287, July 1965. **4.** Giorlando, S. W.: OB/GYN Digest *13*:32, Sept. 1971. **5.** Decker, A.: Case Reports on file, Medical Department, Julius Schmid. **6.** Friedel, H. J.: Md. State Med. J. *15*:36, Feb. 1966. **7.** Roberts, C. L. and Sullivan, J. J.: Calif. Med. *103*:109, Aug. 1965. **8.** Giorlando, S. W., Torres, J. F. and Muscillo, G.: Am. J. Obstet. Gynecol. *90*:370, Oct. 1, 1964. **9.** Abruzzi, W. A.: Western Med. *5*:62, Feb. 1964.

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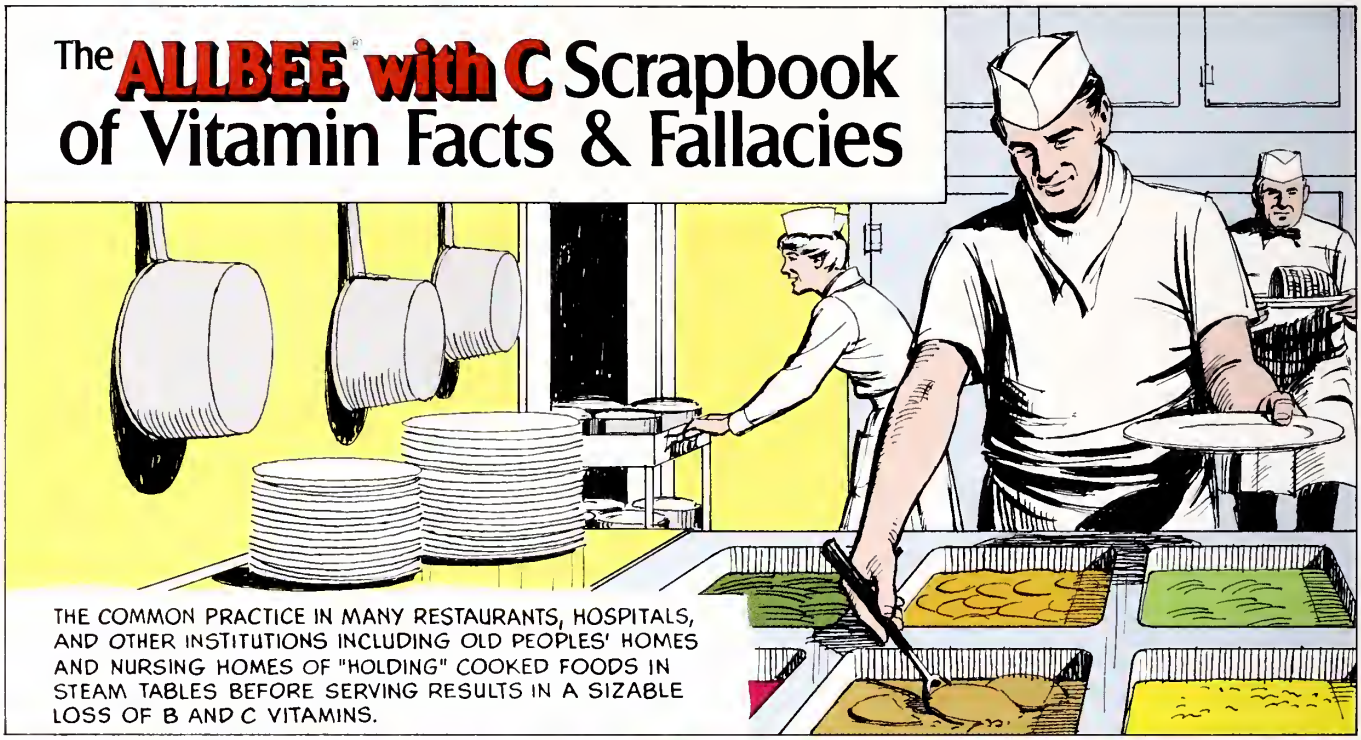

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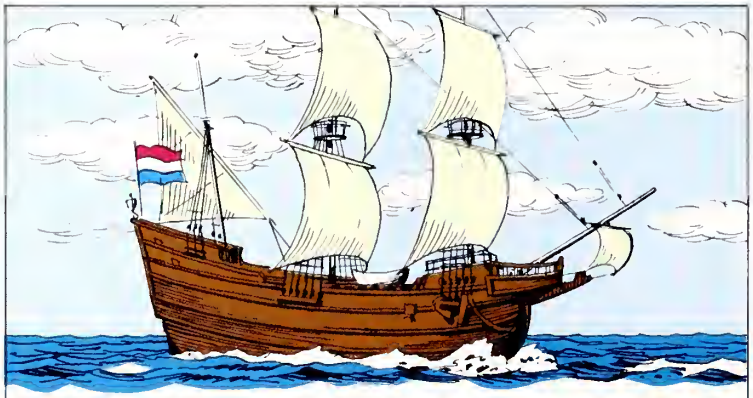

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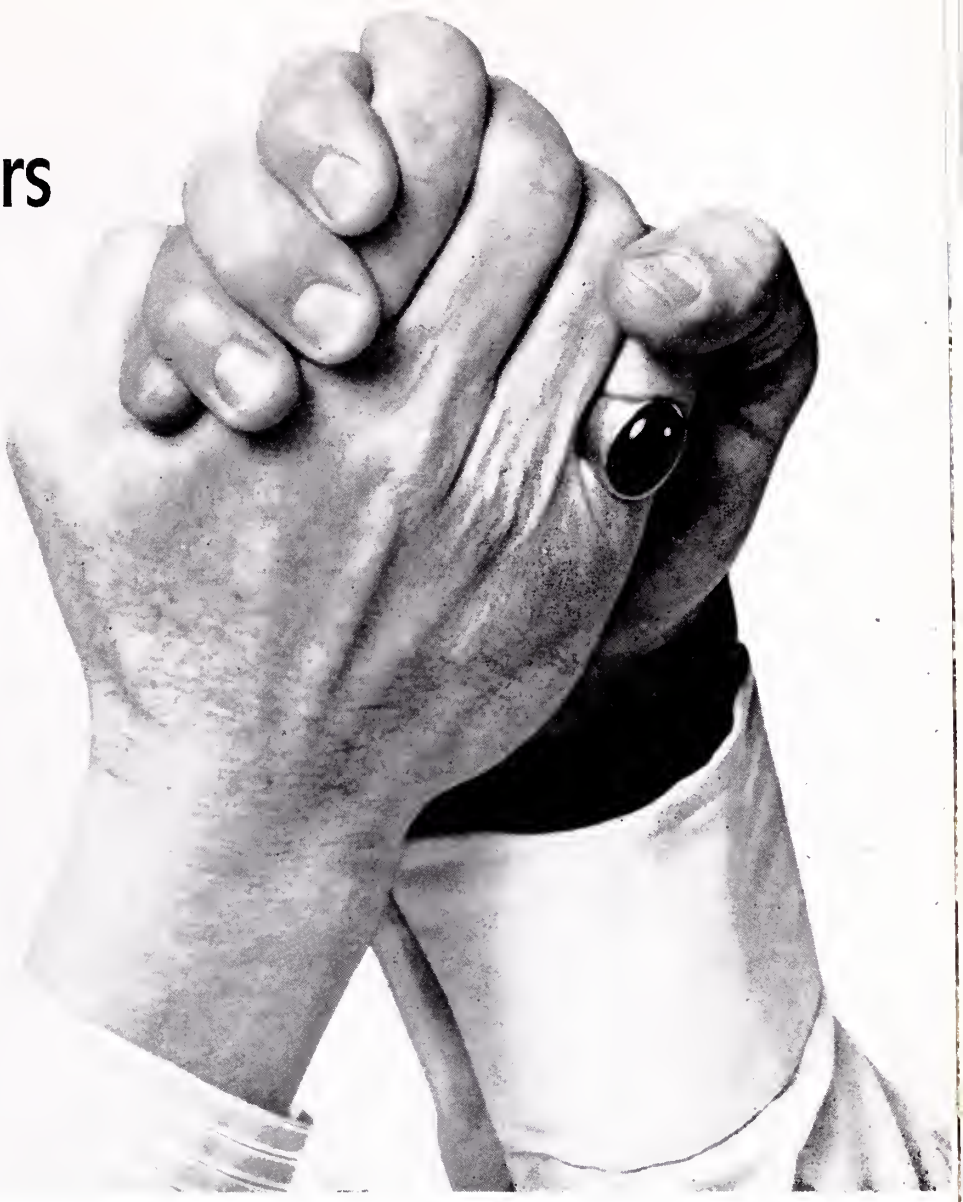

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In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

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Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

MAY, 1974 • VOLUME 61 • NUMBER 5

Rheumatic Fever in Florida

M. E. Groover Jr., M.D. and J. E. Fulghum, M.D.

Abstract: Rheumatic fever in Florida is controversial. To some clinicians it presents a problem of grave magnitude, to others there is no problem. This last attitude prevents the Division of Health from obtaining sufficient funds to develop a more comprehensive Rheumatic Fever Prevention Program. The Bureau of Adult Health and Chronic Diseases through the Heart Disease Control Section provides prophylactic drugs for prevention of secondary attacks to medically indigent patients upon certification by a physician. In 1972, 1,571 persons received drugs through this program (Table 1); oral penicillin—1,056; injectable penicillin—446; sulfadiazine—60; erythromycin—7; and tetracycline —2.

Since rheumatic fever is not now a reportable disease in Florida and no system exists for measuring the incidence of acute cases, a count of death certificates has been the only means of assessing the magnitude of the problem. In 1972 the condition was listed as one of the first five diagnoses on 644 certificates. A study of hospital charts shows that the actual cause of death was rarely rheumatic heart disease. Usually it was a stroke, myocardial infarction, pneumonia, pancreatitis, or cirrhosis of the liver. The presence of a cardiac murmur was usually the reason for adding the rheumatic fever diagnosis. Acute rheumatic fever was listed as the main cause of death in only five cases.

A study of the hospital charts of these five patients revealed that three had typical rheumatic fever with ASO titer greater than 300 Todd units. One was thought to have viral myocarditis with cardiomegaly and fatal congestive heart failure with an ASO titer of 50 Todd units; the other congenital heart defect, bacterial endocarditis, and an ASO titer of 150. This patient was sent home on tubex penicillin, but relapsed and was readmitted with fever, congestive heart failure, and positive blood cultures.

In order to get an idea of the number of nonfatal cases in Florida a questionnaire was sent to 209 hospitals requesting the names of patients admitted with acute rheumatic fever. A total of 164 or 78% replied reporting 178 cases (Fig. 1). The area of greatest prevalence extended from Jacksonville to Tampa.

Methods

In order to more accurately assess the problem, the records of these patients were reviewed in 16 hospitals located in the area of the state where rheumatic fever appeared to have been most prevalent during the preceding five years. A total of 451 charts were examined; 15 were thought to have been miscoded because ASO titers were negative and the history, physical examination, and discharge summary failed to substantiate the diagnosis.

Results

Three hundred eighty two patients were described as having cardiac murmur that could have been caused by a remote rheumatic fever attack. Fifty-four acute cases with elevated ASO titers were found and they were tabulated as to primary or secondary attacks. Those with first attacks and no history of antecedent attacks of sore throat or joint disease are tabulated in Table 2. Three of these were football players, 17, 19, and 21 years

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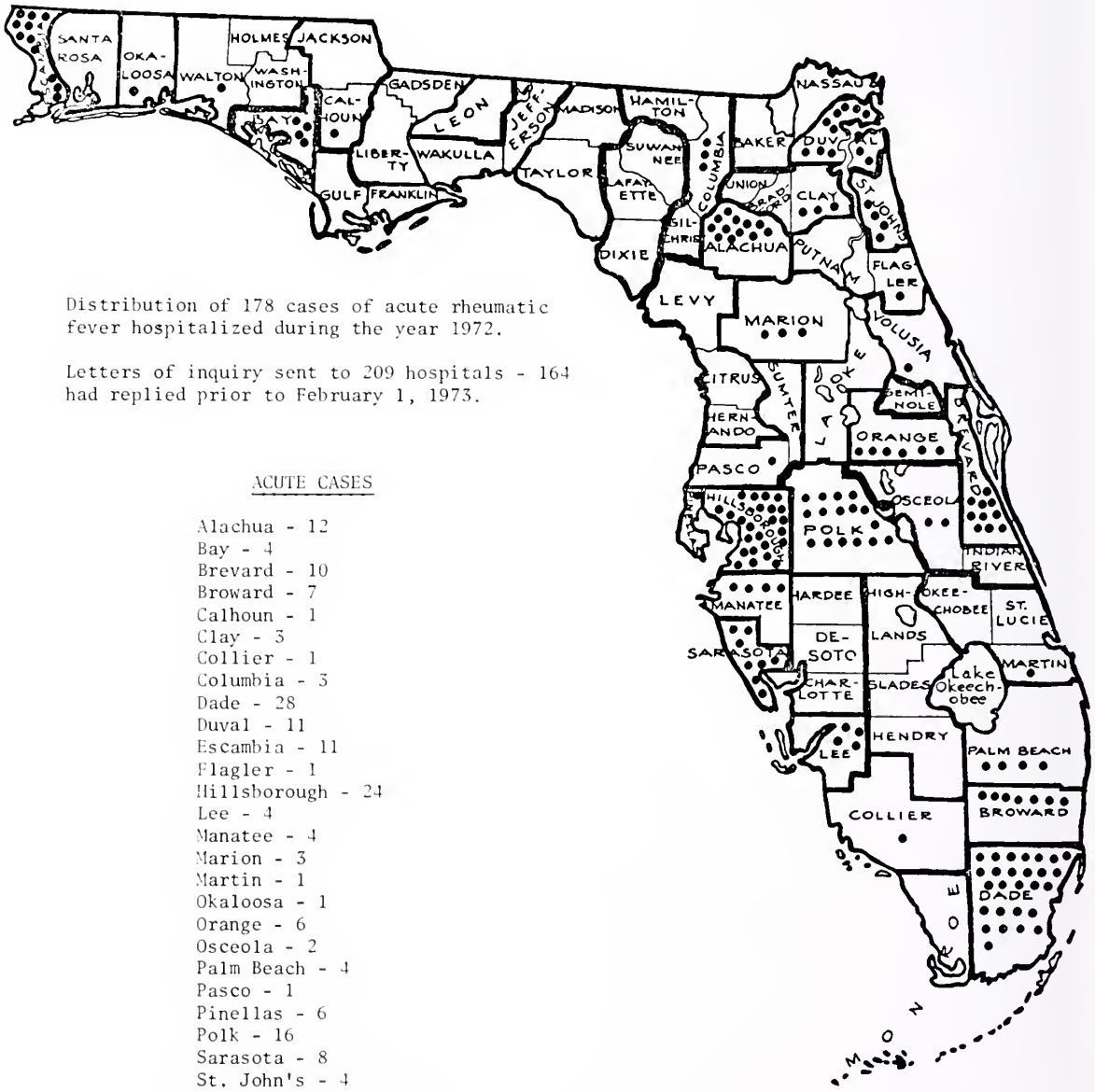

Distribution of 178 cases of acute rheumatic fever hospitalized during the year 1972.

Letters of inquiry sent to 209 hospitals - 164 had replied prior to February 1, 1973.

ACUTE CASES

Alachua - 12
Bay - 4
Brevard - 10
Broward - 7
Calhoun - 1
Clay - 3
Collier - 1
Columbia - 3
Dade - 28
Duval - 11
Escambia - 11
Flagler - 1
Hillsborough - 24
Lee - 4
Manatee - 4
Marion - 3
Martin - 1
Okaloosa - 1
Orange - 6
Osceola - 2
Palm Beach - 4
Pasco - 1
Pinellas - 6
Polk - 16
Sarasota - 8
St. John's - 4
Volusia - 1
Walton - 1

TOTAL: 178

Fig. 1.—Table and map showing distribution of cases of acute rheumatic fever in Florida.

Table 1.—Patients Receiving Prophylactic Therapy Through the Florida Division of Health to Prevent Secondary Attacks by Age Groups for 1967, 1968, 1969, 1970, 1971, and 1972

Age Groups	1967	1968	1969	1970	1971	1972
0-4	13	16	9	4	11	27
5-14	572	561	558	534	543	550
15-24	421	435	516	569	575	665
25-34	97	99	122	120	142	139
35-44	74	77	81	90	98	119
45-54	46	47	55	51	55	41
55-64	24	26	32	38	39	20
65-74	5	4	6	9	14	8
75-84	1	1	0	1	0	2
85-	0	0	0	0	0	0
TOTALS	1,253	1,266	1,379	1,416	1,477	1,571

of age. The 19-year-old with arthritis of the knee which occurred after a football injury would have been missed if it had not been for the ASO titer of 400. There was no mention of heart murmur. The 21-year-old was thought to have traumatic arthritis of the knees until he had an ASO titer of 300. The 17-year-old had a fractured femur and fever developed on the second day after open reduction. This boy had a questionable history of rheumatic fever and an ASO titer of 50 Todd units. It is difficult to say whether these should be counted as acute rheumatic fever cases or not.

Another point of interest in this table is the fact that 19 of the 40 cases were in black females

Table 2.—List of First Attack Patients Showing Allergic Reaction to Penicillin, ASO Titer, and Admission Symptoms with Color, Sex and Age.

Color	Sex	Age	Admission Symptoms	ASO	Allergic to Pen.	Prop. Drugs on Dis.
W	M	6	Tonsillitis, arthritis	50	Yes	No
W	M	19	Acute URL—no strep	400	No	Penicillin
W	M	12	Arthritis—right knee	333	No	Penicillin
B	F	10	Sore throat and joints	500	No	Penicillin
B	M	13	Myositis	625	No	Penicillin
B	F	9	Sickle cell disease	400	No	Penicillin
W	F	5	Acute URL—no strep	166	No	Penicillin
B	F	11	Sore throat 3 wks. ago, impetigo	830	No	No
B	F	12	Nephritis	430	No	Penicillin
B	F	8	Sore throat	800	No	Penicillin
W	M	20	Sore throat and joints, murmur	600	No	?
B	M	16	Nephritis, arthritis	500	No	Penicillin
W	F	5	Impetigo	366	No	No
W	F	7	No hist. sore throat, chorea	166	?	No
B	F	9	Sickle cell dis., diabetes, influenza	60	No	No
B	F	11	Tonsillitis	800	No	Penicillin
W	M	12	Lymph adenopathy, urethritis, arthritis	333	No	Penicillin
W	M	58	Diabetes, gout, murmur	1000	No	Penicillin
B	F	17	C.H.F., cardiomegaly, nephritis	800	Yes	Sulfadiazine
B	F	13	Asthma, tonsillitis	166	Yes	Sulfadiazine
W	M	9	Acute URL—no strep 14 days	400	No	Penicillin
B	F	11	Sickle cell disease, diabetes	333	Yes	Sulfadiazine
W	M	6	Sore throat, arthritis, murmur	90	Yes	Sulfadiazine
B	F	9	Bad cold one wk., painful joints	200	Yes	Sulfadiazine
W	M	18	Influenza—2 wks.	300	No	Penicillin
B	F	19	Postpartum sore throat, arthralgia	333	No	Penicillin
W	M	12	Two wks. sore throat	100	Yes	Sulfadiazine
B	F	9	Tonsillitis, C.H.F., arthritis	333	Yes	Sulfadiazine
B	F	8	Polyarthritis, negative culture	400	No	Penicillin
B	M	21	Football injury both knees	300	No	Penicillin
B	F	11	C.H.F., S.B.E., sickle cell disease	830	Yes	Erythrocin
B	F	7	Polyarthritis, murmur	250	No	Penicillin
W	F	14	C.H.F., polyarthritis	200	Yes	Sulfadiazine
B	F	18	Postpartum, polyarthritis	330	No	Penicillin
B	M	19	Skin wound, B.H. strep, polyarthritis	400	No	No
W	M	28	C.H.F., MI	150	No	?
B	F	13	Tonsillitis, strep throat	600	Yes	No
B	F	9	C.H.F., sickle cell disease	830	Yes	?
W	M	17	Fractured femur, history—rheu. fever	50	No	No disease
W	F	21	Postpartum, history—rheu. fever	75	No	No disease

and only four in black males. This 47% to 10% ratio is difficult to explain. Twenty-three were black and 17 white. The sex ratio was reversed in the whites there being five females and 12 males. The ratio of male to female whites was 30% to 70% while the sex ratio for blacks was males 18%, females 82%. It is also interesting to note that five or 12.5% had sickle cell disease. This would be 21% of the blacks.

Twelve persons were allergic to penicillin. The table shows the patients placed on prophylactic drugs upon discharge from the hospital.

Those patients recorded as having their second attack are listed in Table 3. It is interesting to note that six or 60% of them were allergic to penicillin and were taking sulfadiazine .5 gm twice daily. The other four had received injectable penicillin after their first attack until they stopped medication. One of these had been reported to a county health department and was lost to follow-up.

This table suggests that we should make a more detailed study of sulfadiazine as a prophylactic drug. At the present time allergy to penicillin and sulfadiazine therapy seems to be the leading associate factors to second attacks of rheumatic fever.

Three patients had a third attack and one had multiple attacks (Table 4). The first, a white female age 12, had subacute bacterial endocarditis and relapsed while taking bicillin according to instructions. The second, a black male age 21, had been lost to follow-up by the county health department and had discontinued penicillin because he thought he was well and didn't need it. The third, a black female age 17, had a congenital heart defect, bacterial endocarditis, and was discharged from the hospital taking weekly bicillin injections. She relapsed with a positive blood culture while adhering to the treatment schedule. The fourth patient had many admissions with congestive heart failure following a myocardial infarction. He was allergic to penicillin and was taking sulfadiazine.

Table 3.—List of Patients Showing Those with Second Attack of Rheumatic Fever with Type of Prophylactic Drugs and Notes as to Patient Compliance with Prophylactic Program.

Color	Sex	Age	Admission Symtoms	ASO	Prop. Drug	Notes
W	F	12	C.H.F./S.B.E./congenital heart dis.	400	Bicillin	Lived in Ga. Had no follow-up. Discontinued penicillin.
W	M	15	Sore throat/polyarthritis	250	Bicillin	Bicillin discontinued because it hurt.
B	M	20	Polyarthritis	330	Sulfadiazine	Allergic to penicillin.
W	F	16	Influenza	150	Sulfadiazine	Allergic to penicillin.
B	F	9	Nephritis	250	Sulfadiazine	Allergic to penicillin.
B	F	10	Impetigo/polyarthritis	400	Sulfadiazine	Allergic to penicillin.
W	F	18	Viral pneumonia/polyarthritis/ diabetes/empyema	1000	Penicillin	Discontinued penicillin on physicians advice
W	M	17	Spiral fracture of femur	150	Penicillin	Discontinued penicillin because disliked shots. No rheumatic fever recurrence.
B	F	13	Recurrent polyarthritis	300	Sulfadiazine	Allergic to penicillin.
B	F	7	Anemia/arthritis of knees and hips	100	Sulfadiazine	Allergic to penicillin.

Table 4.—Patients with Third Attack of Rheumatic Fever.

Color	Sex	Age	Admission Symptoms	ASO	Prop. Drug	Notes
W	F	12	Fever/C.H.F. + Blood culture	330	Penicillin	Third relapse while on bicillin
B	M	21	Sore throat/arthritis/C.H.F.	400	Penicillin	Patient last seen five years ago. Was not reported to health department. Lost to follow-up.
B	F	17	Fever/murmur/positive blood culture/congenital defect	150	Penicillin	Relapse with positive blood culture while taking prophylactic penicillin.
W	M	28	C.H.F./myocardial infarction/allergic to penicillin/diabetes/gout	1000	Sulfadiazine	

One patient classed as multiple attacks has had recurrent polyarthritis since a recurrence of nonbacterial pneumonia, and has had multiple admissions for C.H.F.

He had gout and several ASO titer determinations ranged from 800 to 1000. Here again this patient's chart would have been missed for study if it had not been for the several laboratory reports with very high ASO titers.

Summary

Four hundred fifty one medical records bearing the diagnosis of rheumatic fever were reviewed in 16 hospitals, 15 were considered miscoded and 382 patients had chronic valve disease. Only 54 acute cases with elevated ASO titer were tabulated. Forty of these cases were first attacks and the patients would not have had the opportunity to profit by prophylactic drugs to prevent secondary attacks. An interesting color, sex ratio was noted in the first attack group.

Among the group of second attacks, six patients were allergic to penicillin and were taking sulfadiazine. The other four had been placed on injectable penicillin and had discontinued medication without the knowledge of their physician. None of these four patients had been on the rheumatic fever follow-up list of any county health department.

Two of the group of patients having third and fourth attacks were seriously ill with bacterial endocarditis. They relapsed while taking weekly injections of penicillin. Only one had been reported to the county health department and he had been lost to follow-up for over five years.

One of the 54 cases of acute rheumatic fever had been reported to a county health department for follow-up services.

A program for the prevention of rheumatic fever would have been hard pressed to prevent the 40 first attacks since there was no prior knowledge of the disease. The patients allergic to penicillin were probably not preventable since they were under constant care by their private physicians.

The one case reported to a county health department was a health department failure, in that adequate follow-up was not maintained.

▶ Dr. Groover, P.O. Box 210, Jacksonville 32201.

Reporting of Rheumatic Fever

A Task Force on Rheumatic Fever met at 10:30 a.m. in Tampa at the Host Air Port Hotel. The Task Force was composed of representatives from: the Division of Health; the Division of Children's Medical Services; the Florida Heart Association; the Florida Medical Association, and the Florida Pediatrics Society.

After an indepth discussion of the problems related to the prevention of rheumatic heart disease the Task Force made the following recommendations:

1. Changes in the drug order form relieving the physician of the responsibility of certifying to the patient's financial status and deleting certain drugs considered to be not effective in preventing secondary attacks of rheumatic fever.
2. They recommended that physicians in the state report rheumatic fever fully and completely. It was further recommended that the Florida Heart Association assist in the reporting of rheumatic fever by sending periodic notices to physicians urging them to report.
3. Letters be sent to the county medical societies requesting that physicians be reminded to report rheumatic fever on the Epidemiology Report card. The Division of Health should tabulate reported cases periodically by counties.

The above recommendations are being implemented. All physicians are requested to report rheumatic fever on the weekly Notifiable Disease Case Report Card. PD 105.

In Defense of Long-Term Psychotherapy

Howard Golden, M.D.

The recent decision by the Florida Medical Insurance Trust eliminating Blue Shield coverage for individual psychotherapy (coverage that Florida doctors and their families had put to massive use) caused an abrupt and painful awakening to many of us who are practicing psychotherapists. It was all the more troubling to learn that the ruling, apparently based on purely fiscal reasons, was made, not by insurance company executives, but by members of our very own Florida Medical Association.

It was simply too expensive, our fellow physicians told us. You can have the other benefits of Blue Cross and Blue Shield, but no more of that long-term psychotherapy; we can't afford it. We must assume that when it came to a cost-effectiveness analysis, long-term individual psychotherapy, in the minds of the doctors who made the decision, failed the test.

And if this were not enough to make a Florida psychiatrist wonder who his friends are, it was recently brought to my attention that the State Board of Medical Examiners now wants to know if an applicant for State Boards has been in psychotherapy. And if so, why?

Well, is that the proper business of the Florida Board? Is that a legitimate question to ask of a doctor who wants to practice medicine in our state? I suspect, if the matter were brought up at a cocktail party, a Board member might answer: "You're damn right it is! We don't want any crackpots practicing in our state."

I don't either, but I fear that putting such a question on the application will not produce the desired effect but may indirectly result in its opposite. A medical student, house officer or any prospective Florida practitioner may simply not get help for his or her emotional problem or at least delay treatment until a state license is safely in hand. How to calculate the effects of this delay in treatment, either in human misery or lost medical students, is something I can't answer.

A disagreeable alternative for the Florida Board applicant is to just lie about past psychotherapy. This is certainly a tempting way of dealing with the problem since the very existence of the question implies that some of those who have been in psychotherapy will be denied a Florida license. So, one might reason, why put oneself in jeopardy by being truthful?

Those applicants who do answer truthfully, or intend to, will now have to wonder what information told to his psychiatrist will be used against him by the Board or what information he must now withhold in order to protect his chances to practice medicine in Florida; thus wreaking havoc with the principles of confidentiality and privilege that are essential to the successful outcome of treatment.

Awkwardly enough, the Florida Boards' decision comes at a time when medical students are encouraged by sophisticated, compassionate deans to seek psychotherapy rather than to become disabled by their problems.

It seems clear to me now that there are some physicians in the State of Florida, some of them in high and powerful places (e.g., Florida Medical Insurance Trust and State Board of Medical Examiners), who, either by lack of training, experience or inclination, do not fully comprehend the nature of long-term psychotherapy and regard it somehow differently from other treatments of severe, often disabling, occasionally life-threatening and tragically, sometimes fatal disorders.

The blame for this lack of understanding rests largely, I feel, on the shoulders of the psychiatric community. Those of us who practice psychotherapy have been cloistered for so long in our comfortable offices that we didn't know or didn't care that many doctors "out there" have no idea what we do, why we do it, to whom we do it, or even who we are.

And so, belatedly, I step out of my dimly lit office into the sunshine to venture these opinions which, while strictly my own, do, I feel, represent the prevailing psychiatric opinion in the community where I practice.

Delay Gratification

In medical school, you may recall, it is frequently emphasized that the psychiatrist must be able to "delay gratification." The surgeon gets

to the cause of the trouble, cuts it out in a matter of hours and sees his grateful patient walk out of the hospital in a week or two. The internist examines a sick patient, deduces the origin of the illness, applies the proper treatment, and again, in a relatively short period of time the therapy is complete, the patient and his family thankful and the doctor satisfied. In psychotherapy, on the other hand, the course of an illness and its treatment may extend over a period of several years.

Even among psychiatrists not everyone is interested in undertaking the treatment of a patient that might last for five or even more years before significant improvement takes place. Not all psychiatrists have the temperament or desire to do that kind of work and many of us who do feel that we must ourselves undergo such a treatment. We must do so not only to learn the technique first hand but also to clear out or become aware of our own conflicts so that we do not *unconsciously* abuse or exploit our patients for our own aggrandizement. I emphasize the word unconsciously because ethical physicians do not need to be reminded that we do not willfully or consciously take advantage of our patients. But the intensive nature of this form of psychotherapy makes the psychiatrist (as well as any doctor in an intensive relationship with a patient) peculiarly vulnerable to using the patient to satisfy some unconscious, unresolved conflict of his own. For example: adolescent patients frequently suffer a great deal of turmoil and confusion as they try to make choices about what to do or not do and the doctor is often in an advantageous position to give them advice. But if the doctor is harboring unconscious resentment toward his own parents because he felt they were too strict or too rigid when he was growing up, he might encourage his teenage patients to do the kinds of things he wanted to do but never could. Thus, in the guise of offering therapeutic advice, the doctor has unwittingly attempted to resolve his own personal problems from the past at the expense of his patients' well being.

This example is a fairly obvious one. In practice, the circumstances are often far more complex and may be impossible to deal with unless the therapist has undergone the lengthy process that leads to the kind of self-awareness which enables him to keep the life of his patient separate from his own private mental life.

Some therapists take another step and undergo more specialized and extended postresidency training at psychoanalytic institutes in order to further develop their therapeutic skills.

I should add here that most of the psychiatrists who do long-term psychotherapy also use in their practices the other therapeutic modalities that are available such as drug treatment, shock therapy, group therapy, family therapy, and short-term supportive or crisis-oriented therapy. Indeed, it is a cardinal rule in psychiatry, as well as in all of medicine, that the physician apply the least amount of treatment necessary to effect a cure. But there are some conditions that simply do not or have failed to respond to the briefer forms of treatment and long-term psychotherapy is then indicated.

This is often difficult for patients to accept, partly because we live in an age that reveres the rapid, the mini, the micro, and we have become conditioned to expect that almost anything can be done more quickly than before or reduced in size with no loss of efficacy. This attitude has influenced the development of some novel forms of therapy such as encounter group or "primal scream therapy." Whether or not such approaches will stand the test of time and become part of every psychiatrist's armamentarium remains to be seen. It is obvious now, however, that such treatment, regardless of how dramatic or well publicized, does not work for every one and we can certainly understand the disappointment of a patient who goes with high expectations to a psychiatrist for a "few sessions" and ends up in psychotherapy for a few years.

What makes psychotherapy such a lengthy, extraordinarily complex process is, of course, dependent on what makes people disturbed in the first place.

While the various schools of thought regarding human behavior often appear to be at odds with one another and sometimes seem to be vying for supremacy, most do, it seems to me, have at least one thing in common; that is the idea, as Wordsworth put it: "The child is father of the man." The experiences of our growing up profoundly influence what we are as adults, and so the effort of long-term psychotherapy usually focuses on this simple, fundamental idea, with its rich, varied and obscure nuances.

Each of us is born with his own set of inclinations that he must somehow make fit into the little world in which he finds himself. Because the human infant cannot survive for very long on his own, he begins, in the crib, to adapt himself

as best he can to get what he needs. He learns that if he bites the hand that feeds him, he's not going to get fed, so he thinks twice before biting. Conversely, if the hand that feeds him is unpredictable or inconsistent or not trustworthy, he learns that too and comes to expect it of the world. And as he grows and matures, he continues, without even being aware of it, to adapt and mold himself in order to best sustain the love and avoid the wrath of his parents, and later the world. This usually means controlling, submerging, and redirecting his own aggressive and sexual desires. These survival techniques are incorporated into our personalities, first through trial and error and then through daily repetition and just rarely, contrary to the movie version, through a major traumatic event, to become the ways in which we deal with the world around us.

The success or failure of these adaptations are usually related to the degree of emotional maturity possessed by the parents. If the parents make inordinate or excessive demands by being, for example, either too punitive or too permissive, they may exceed the child's capacity to mold himself sufficiently to get along, and then trouble may start. It may begin right then in childhood with an observable disorder or it may smolder beneath the surface only to burst out later in adolescence or in adult life. Or the task of becoming civilized in an irrational milieu is carried out at such an enormous cost of creative energy that there is little left over to develop one's own true potential.

Psychotherapy is a lengthy process because the earlier one learns something and the more often it is reinforced, the more effectively it becomes ingrained in the personality and character and, therefore, the more difficult it is to change. When a patient comes in for psychotherapy at age 35, it means he has had 35 years of practice at being what he is and it is going to be very, very hard to learn how to be different.

But change is possible, although difficult, through the medium of intensive psychotherapy, because during the treatment the feelings and expectations that the patient had towards his parents are reexperienced in an emotionally powerful way and transferred on to the person of the therapist. This circumstance, which begins to happen even before the patient is aware of it, is, many feel, the essential ingredient in therapy and the vehicle by which recovery takes place. For in the process of its explication the patient comes to see the many ways in which he has unconsciously been trying to work out some old childhood misunderstandings, confusions, resentments, etc., while at the same time trying consciously to carry out his responsibilities in the real world. It's hard to do both.

An example might be someone who is always late for work because he is unconsciously trying to fight old childhood battles with his parents who insisted that he conform to their ideas of schedule and regularity. This is, of course, an over-simplification, but perhaps one can get the idea of how the excess baggage of the past can rob a person of his ability to function at his best and enjoy his life.

Preventive Medicine for Society

Psychotherapy is a treatment not only of an individual, but it is in a way preventive medicine for society as a whole. The successfully treated person becomes a better, healthier parent and thus can break the generational spiral of disturbed, unhappy parents who produce disturbed, unhappy children who become themselves disturbed, unhappy parents who produce disturbed, unhappy children, ad infinitum.

One of the popular myths about psychotherapy is that someone might engage in it as some kind of intellectual pastime; that a bored person of means and intelligence might take it up as a sophisticated form of entertainment. While I have not seen such a person in my practice, I will grant that someone might enter therapy with that kind of idea in mind, but if he stays in therapy more than a month or two it is because he was kidding himself about his reasons for starting and, in fact, needs therapy and needs it badly. No one is in psychotherapy for fun, because it isn't fun. It is hard work and from time to time painful work. Some patients actually experience an increase in anxiety or depression in the initial stages of therapy. To discover as adults that we are living out our lives in an unconscious effort to satisfy some ridiculous (to the adult) childhood fantasies can be, to put it mildly, a disturbing and humiliating experience. But that is often the first step towards establishing a more comfortable, more productive, more satisfying way of life.

Not everyone can tolerate this kind of therapy. A patient must have considerable strength of character and determination in spite of his problems in order to carry it through, and so many patients are bright, strong-willed people who do

not appear on the outside to be suffering even though their personal torment may be intolerable. Psychotherapy is no luxury for such a person; it is a necessity. Yet large segments of our population, both lay and professional, do not fully understand this and may actively or passively interfere with psychotherapy because of prejudice, fear, or simple lack of education.

If a doctor and his family are brought to the emergency room with torn and broken bodies from a car wreck, the medical community will rush to their side and with consummate skill and dedication do everything that they are humanly capable of in order to restore the injured to health.

The healing of a broken or deformed marriage, family or personality may be less dramatic but, in fact, may be even more important. The medical profession, cognizant as it is of its own high suicide rate, ought to do everything it can to make psychotherapy easier to obtain rather than put obstacles in the path of someone who needs help.

The mind and the body exist together. As physicians, we are practitioners of the art of healing the whole person; that is our commitment. We cannot turn our backs on that responsibility.

▶ Dr. Golden, 717 DuPont Plaza Center, Miami 33131.

Three officials of the Woman's Auxiliary to the Florida Medical Association paid a visit to Governor Askew in February to present him with a complimentary copy of the Auxiliary cookbook, "What's Cooking, Doc?" Mrs. W. H. Mathews of Jacksonville, President of the Auxiliary, makes the presentation as Mrs. Samuel L. Renfroe and Mrs. Eugene G. Peek Jr., look on.

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MEETINGS

Approved by FMA Committee on Continuing Education

MAY

Master Approach to Cardiac Emergencies, May 2-4, Contemporary Hotel, Disney World, Orlando*

Anatomy of Infection—Endotoxic Shock, May 3, South Miami Hospital, Miami. For information: Division of Continuing Medical Education, South Miami Hospital, 7400 S.W. 62nd Ave., Miami 33143

The Management of the Critically Ill Patient, May 3-4, Hilton Hotel, Gainesville**

An Intensive Day in Critical Care Medicine, May 4, Hilton Hotel, Gainesville**

Clinical Care of Bone Tumors, May 9-11, University of Florida, Gainesville**

Microneurosurgery, May 9-12, Innisbrook Resort & Gulf Club, Tarpon Springs**

Workshop in Electrocardiography, May 9-13, Tides Hotel & Bath Club, Redington Beach. For information: Rogers Heart Fund, 601-12th St., St. Petersburg 33705

Rehabilitation Potentials of the Severely Physically Handicapped, May 10-12, Miami*

Instruction Courses in Coronary Care for the Practicing Physician, May 13-18, University of Miami School of Medicine, Miami*

Medical Audit Team Seminar, May 16-17, Carlton House Resort Inn, Orlando. For information: Florida Hospital Assn., Box 6905, Orlando

Endocrinology & Metabolism 1974, May 16-18, Mt. Sinai Medical Center of Greater Miami, Miami Beach. For information: Mt. Sinai Medical Center of Greater Miami, 4300 Alton Rd., Miami Beach 33140

Acute Coronary Care, May 17-18, Cedars of Lebanon Health Care Center, Miami. For information: Seminar Coordinator, Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

Respiratory Disease Physicians Seminar, May 19-20, Turtle Inn, Atlantic Beach. For information: Florida Lung Association, P. O. Box 8127, Jacksonville 32211

Instrumentation in Cardiology, May 24-26, Port O'Call Resort, St. Petersburg. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

JUNE

Clinical Pathological Conference — Management of Severe Infection, June 7, A. Vance Morgan Educational Center, Miami. For information: Division of Continuing Medical Education, South Miami Hospital, 7400 S.W. 62nd Ave., Miami 33143

Eighth Annual Workshop in Electrocardiography, June 17-22, Sheraton Olympic Villas, Orlando. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

AUGUST

Postgraduate Obstetric-Pediatric Seminar, Aug. 15-17, Pier 66 Hotel, Fort Lauderdale. For information: A. F. Caraway, M.D., P.O. Box 210, Jacksonville 32201

▶ Western Hemisphere Nutrition Congress IV, Aug. 19-22, Americana Hotel, Miami Beach. For information: AMA Council on Foods & Nutrition, 535 N. Dearborn St., Chicago 60610

SEPTEMBER

Teaching Conference in Radiology, Sept. 11-15, Doral Country Club, Miami*

By Arrangement In-Service Tutorials in Family Medicine; Neonatology; Oncology, Ophthalmology; Otolaryngology; Pediatric Cardiology; Radiology; Renal Disease, Hypertension and Renal Dialysis; Urology*

By Arrangement On-Site Community-Hospital Program: "A Positive Approach to Cancer Diagnosis and Treatment." University of Miami School of Medicine, the Comprehensive Cancer Center of Greater Miami, National Cancer Institute, U.S. Public Health Service, and co-sponsored by the American Cancer Society, Florida Division*

By Arrangement Visiting Lecturers Program—a program designed to provide continuing education based on specific requests from local medical groups and hospitals*

OCTOBER

▶ American College of Gastroenterology, Oct. 20-23, Americana Hotel, Miami Beach. For information: Mr. Daniel Weiss, 299 Broadway, New York 10007

▶ American College of Surgeons, Clinical Congress, Oct. 21-25, Miami Beach. For information: C. Rollins Hanlon, M.D., 55 E. Erie St., Chicago 60611

▶ American Society of Therapeutic Radiologists, Oct. 30-Nov. 4, Sonesta Beach, Key Biscayne. For information: Sheila A. McGing, 20 N. Wacker Dr., Rm. 2920, Chicago 60606

NOVEMBER

▶ Interstate Postgraduate Medical Association of North America, Nov. 4-7, Diplomat Hotel, Hollywood. For information: Mr. Roy T. Ragatz, Box 1109, Madison, Wisc. 53701

Hand Surgery—1974, November 15-17, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Miami*

DECEMBER

"Changing Concepts in Infectious Diseases for Obstetrics & Gynecology," Dec. 5-6, Hilton Hotel, Gainesville**

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*For Information: Contact the Division of Continuing Education, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610.

▶ National meetings being held in Florida.

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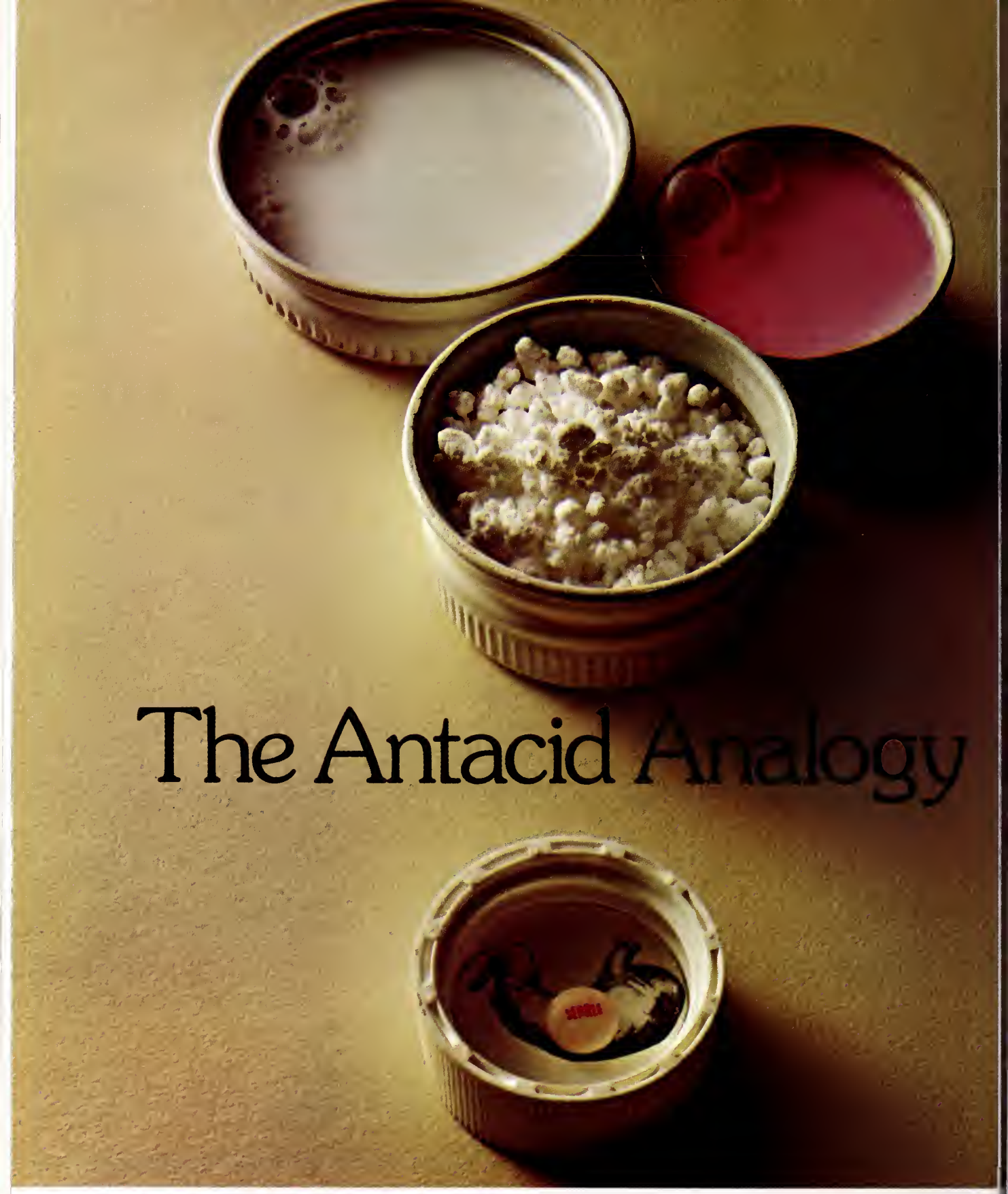

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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Special Articles

DWD Legislation It Really Isn't Necessary

FRANKLIN J. EVANS, M.D., LL.B.

About two years ago I wrote an article for the Journal of the Florida Medical Association[1] in which I expressed strong opposition to the need for "Death with Dignity" type legislation (though not to the principle or concept of the right to die with dignity). In essence my opposition to the bill introduced in the Florida legislature centered around these arguments:

1. The bill provided absolutely nothing that could not be done without it, thus obviating the need for such a bill since it accomplished nothing at all.
2. The ultimate decision whether to continue to prolong life rests with the physician and the patient and/or his family, and cannot be decided by legislation, therefore, this bill was superfluous and unnecessary.
3. What constitutes death with dignity is the physician's responsibility which requires professional judgment and cannot be legislated.
4. The bill was vague, confusing and ambiguous and created more problems than it solved, besides making enforcement virtually impossible.
5. Such legislation, if passed, eventually would lead to an increase in malpractice suits because the physician would be bound by its restrictive provisions and would be placed under the impossible burden of satisfying the legislative and public consensus requirements on the one hand and his professional training and judgment on the other.

Once again, as a new legislative session has rolled around, the perennial bill with the catchy title is up before the legislature for its renewed consideration. This time the sponsor has high hopes for passage of his bill, his optimism stemming from the fact that part of his bill (only the first part of three parts) passed the Florida House of Representatives, although by the narrow margin of six votes. Yet the passage of time has in no way lessened or diluted the arguments presented previously in opposition to this proposed legislation. In fact, the opinions and attitudes expressed by many prominent and knowledgeable individuals (more knowledgeable, at least, than senior citizens and TV talk shows) in the intervening two years raising doubt as to the propriety and/or necessity for this type legislation, fortify and enhance the previous arguments and lend added weight and authority to the contention that it really isn't necessary. For example, at the hearing before the U. S. Senate Special Committee on Aging in August 1972, Senator Frank Church, Committee Chairman, was dubious of the need for this legislation. He pointed out ".... under the present state of the law, I have no doubt that a person has the perfect right at any time in his life in any stage in the particular illness to refuse treatment." Senator Charles Percy of Illinois, a Committee member, added, "Isn't the question, though, whether or not a document is necessary when, under existing law, a person has a perfect right, if mentally competent, to refuse all of the medications?" The law on this point was well settled as long ago as 1914 when the eminent Judge Benjamin Cardozo, subsequently Chief Judge of the New York Court of Appeals and later Justice of the United States Supreme Court, in the case of Schloendorff vs Society of New York Hospital (105 NE 92, N.Y.) declared, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body...." The Supreme Court of New Mexico in 1962 went even further in the case of Woods vs Brumlop (377 P.2d 520) when it stated, "An adult person if he be of sound mind, is considered to have the right to determine for himself whether a recommended treatment or surgery shall be performed upon him, and to have the right even to expressly prohibit life-saving surgery

Dr. Evans, an attorney as well as a physician, is Speaker of the FMA House of Delegates.

or other medical treatments." And as recently as last year, a Pennsylvania trial court ruled that a mature, competent adult may refuse to accept medical recommendations that may prolong life, because the right of privacy includes the right to die.

At the National Congress on Medical Ethics in Washington last year, both Dr. Derwood Lepley Jr., Chairman of the Department of Thoracic and Cardiovascular Surgery at the Medical College of Wisconsin, and Robert B. Murphy, general counsel to the State Medical Society of Wisconsin, warned that legislation concerning the ethical considerations surrounding the death of terminally ill patients would be more harm than help to the medical profession. Dependence on legislation in this area will pave the way for legal regulation of other aspects of medical practice, they argued, and no statute or court decision can determine satisfactorily such medical matters as the criteria of death or the time of death or what constitutes death with dignity.

At the hearings of the U. S. Senate Special Committee on Aging in August 1972, Dr. Lawrence V. Foye Jr., Director of Education Service, Veterans Administration, referring to what he described as "the popular but obscure phrase, death with dignity," and to its counterpart, the "living will," stated that such a document "in which the patient permits and instructs his physician to let him die if his condition is hopeless, really solves nothing but does create problems of its own." He later explained that "such approaches as legalized euthanasia and the 'living will' are based upon the misconception that the point of hopelessness can be known with accuracy and that the physician may uselessly prolong suffering beyond that point unless forbidden by law or similarly excused from his obligation. I fear that unless people understand the false reasoning behind these concepts the physician's hands may be tied in just those cases where his skill and modern technology can make the greatest contributions to the saving of lives and the control of disease."

It is significant that at this same Senate hearing Dr. Elizabeth Kubler-Ross, noted Illinois psychiatrist and author of the book, "On Death and Dying," stated emphatically that she was "very leery of that bill" (referring specifically to Dr. Sackett's bill in the Florida legislature), and when asked why she replied, "I am afraid to legalize bills like this because I am afraid of the loopholes which would make it possible to 'eliminate' people's life when they become too costly or too much of a burden on us."

Early in 1972 during a symposium on ethics, law and theology held in Chicago by the Judicial Council of the AMA, one of the participants, Andre E. Hellegers, M.D., Director of the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics, Georgetown University, Washington, D.C., commenting on laws about death with dignity, said, ". . . .how would such laws be applied, regardless of the good intentions of those who write them. I don't know of any law which today forces a physician to keep a patient alive. . . ." Later in the discussion he remarked, "I'd be terribly afraid that if there were a law about death with dignity, very shortly afterwards you'd have to write a Good Samaritan law. A physician would say, 'I'm not going to pound on this guy's chest because if that case turns out sour, I'm going to be up in court for not letting him die with dignity.' "

If this discussion and documentation were all there is to say on the subject it should be enough to sway and convince even the skeptics and the nonbelievers of the uselessness and needlessness of DWD legislation. But there is more, lots more.

Since passage of part of Dr. Sackett's bill in last year's legislative session, even graver and more portentious reasons of objection have surfaced. There is little doubt in the minds of those who have followed this subject closely that DWD-type legislation is the opening wedge in a calculated effort to legalize euthanasia. Dr. Sackett may protest and deny the acknowledged link between "death with dignity" and euthanasia, but in his testimony before the U. S. Senate Committee on Aging he commented that "euthanasia is more closely akin to death with dignity than it is to mercy killing." The meaning of this comment is beyond me since "mercy killing" is inherent in the definition of euthanasia and the latter has always been equated with so-called "mercy killing." Be that as it may. If death with dignity type legislation passes any state legislature, it is a foregone conclusion that forthwith a vigorous campaign to legalize so-called "mercy killing" will follow as it is a well-known fact that one of the prime sponsors of the DWD bill in the Florida legislature was the American Euthanasia Foundation, Inc.

The far-reaching extent to which legalized euthanasia can be carried is well documented in the annals of history, past and recent. In a recent

article Professor Charles E. Rice of Notre Dame University Law School said, "The euthanasia drive is first put in voluntary terms: a person should have the right to decide when to die. But it will immediately be extended to those who cannot communicate but who are presumed would ask to be killed if they could. And it will be extended to those who are not even sick and who do not want to die but who would if they knew what was good for them. The retarded, the senile and the simply aged are the obvious targets of euthanasia. But it will predictably be extended to other 'undesirables' as well. It is significant that the Nazi extermination of the Jews grew out of the euthanasia program initiated for the supposed benefit of mental patients in 1939."

Let me point out an interesting and meaningful facet regarding these efforts to legalize euthanasia—every medical society that has taken a position in support of the concept of death with dignity has emphatically rejected euthanasia as "not in the province of the physician" (quoted from a statement adopted by the New York State Medical Society early in 1973). At its annual meeting in October 1973 the Pennsylvania Medical Society used even stronger language when it declared, "Euthanasia, the active termination of life through the administration of a lethal drug or the use of a lethal instrument, is unjustifiable taking of a human life and exceeds proper medical practice." And in December 1973 the House of Delegates of the American Medical Association adopted this policy statement: "The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association."

To lend heft to his stance on the DWD issue, Dr. Sackett repeatedly reminds his audiences and the news media that 15 states now have similar proposals before their legislatures. So what? How much urging does it take to get a legislator to introduce what obviously and admittedly is a catchy, publicity-attractive, euphoniously-titled bill? There are (to use Dr. Sackett's own pet term) "kooks" in state legislatures as in all areas of life. Witness a Florida legislator who has prefiled a memorial to the U. S. Congress asking that the dependent-deduction feature of the Internal Revenue Code be modified so that the larger the family (above one child), the more income taxes it would have to pay by losing deductions for dependents? What next in the name of population control?

There is no question that Dr. Sackett and his DWD stance have generated enormous support and publicity—but from whom? From talk shows? From public opinion polls? From senior citizens? From news media? Yes, to be sure; but how about those who would have to implement this legislation if it ever became law; namely, his fellow physicians? Here is the ironic paradox—little, if any, of his support comes from the medical profession. On the contrary, none of the medical associations quoted above called for passage of such legislation (even though they supported the concept or principle of DWD). Even more significant, the Board of Governors of the Florida Medical Association at its meeting in October 1973 voted unanimously to oppose Dr. Sackett's bill in the Florida legislature—on the grounds that the criterion of death, the time of death, or what constitutes death with dignity are the physician's responsibility requiring professional judgment and should not be the subject of legislation. In a broad observation on the decision to discontinue resuscitative measures, the British Minister of Health in the House of Commons in March 1968 stated, "No attempt should be made to lay down. . . .rules which doctors should observe in reaching what must be a clinical decision."

This may well be the year of decision for DWD legislation. It is hoped that this critique on the reasons for opposing its passage may help bring about its final demise.

1. Evans, Franklin J.: Is This Legislation Really Necessary? JFMA 59:51-53 (Mar.) 1972.

▷ Dr. Evans, 147 Alhambra Circle, Coral Gables 33134.

Maturity begins to grow in a person when his concern for others outweighs his concern for himself.

Death With Dignity A Legislative Necessity

Walter W. Sackett, M.D.

Because of widespread concern not only in Dade County and Florida but countrywide, the issue of Death With Dignity has become one of continued and deep consideration on the part of the people of America and on the part of the various news media as well as of the legislative bodies of the United States.

In articles in the Florida Medical Association Journal of 1972, Dr. Franklin Evans and I placed our opposing views on this subject; however, it seems we both agree on the philosophy of death with dignity but disagree on whether the area should be the subject of legislation or not. I, naturally, in my position as a Representative in the Florida legislature from Dade County feel it definitely does, and I will attempt here to point out those reasons that seem to make it paramount such legislation be enacted. Widespread correspondence and contacts have convinced me to a point far beyond my own personal convictions that legislation is urgently needed; unfortunately, Dr. Evans does not have these opportunities else he might be of a different opinion.

1. The New York Medical Society approved the philosophy of Death With Dignity, as well as the American Medical Association and the American Hospital Association. Written publicly, a spokesman for the American Hospital Association said in essence that with this philosophy accepted, hospital staff and attendants in a bonafide institution will need protection against those who might sue them for malpractice, namely on the basis of omission of treatment.

2. Two circuit judges in Dade County, one eight years ago, had differing opinions on the subject. One ordered that a woman patient with a terminal illness have her leg amputated when she dissented. Another judge in Dade County within the last two years said that a woman should be allowed to forego painful blood transfusions in an intractable anemia.

3. Thirty-eight circuit judges in the State of Florida in a recent poll replied that there is definite need of legislation in this area, some declaring so vehemently. The only dissenting judge protested violently against legislation and from his expression I was sure he was a valid supporter of the "Right To Life" philosophy, dubbing me as a "Hitler," a "killer." I have had judges from all over the country writing me in favor of legislation, among them a federal judge from Colorado. It would seem that circuit judges, who will be appealed to in such cases, are seeking guidance in this matter.

4. Fifteen states have followed the initial lead of Florida in presenting similar legislation. Not all of these can be said, as Dr. Evans alleges, to be a result of an effort to obtain PR for the various introducing legislators; there has to be some sincerity in such endeavors. Governor McCall of Oregon requested his legislature to consider the subject.

5. The United States Senate held a hearing on this subject about a year ago, thus manifesting its concern.

6. One of my strongest House opponents (a physician) right along from the beginning has recently requested to cosponsor a constitutional amendment in the State of Florida which would add "death with dignity" to the basic rights—the "right to life, liberty and the pursuit of happiness." At the time I proposed such a constitutional amendment he was an ardent opponent. I must assume he is about to become a supporter of sorts.

7. A letter from the Florida west coast detailed the measures an about-to-become a widow had to undertake before she was permitted to allow her incompetent and terminally ill husband to die; she cited appeals to her lawyer, a judge, the state's attorney, the Attorney General of the State of Florida, with no results whatever forthcoming.

8. I, myself, had a terminally ill patient who begged me to allow him to die, to which I agreed, but after he became incompetent, the ruling member of the family insisted that I do everything to keep him alive so that this patient was put

Dr. Sackett is a Democratic member of the Florida House of Representatives from Dade County.

through the horrors of a prolonged death process. Had the "Living Will" been a legal document, I could have complied with his request.

9. One of the doctors in an institution for *severely retarded,* in response to a question as to what percentage should be allowed to die, replied, "90% should be so allowed." My next question was, "Why don't you let them die?" He promptly replied that he would if we in the legislature would give him the legal protection providing he had consent of parents or guardians, where they exist, and the agreement of proper medical authorities that any particular case was a hopeless case.

10. The most convincing plea of all comes from those thousands of letters I have in my files in Tallahassee and Miami on the part of old folks, predominantly from the St. Petersburg area, who want this right for themselves after having seen their card or shuffleboard playing mates uselessly subjected to a death prolonging process.

This has become a national matter of concern but unfortunately doctors, as always, have taken a "hands off" attitude, yet when legislation is passed and it affects them, they protest violently. To cite an example, in 1941 I paid $35 a year for malpractice insurance; today I pay $2,500 for the same insurance. The medical profession is struggling on a legislative basis to ease restrictions in this area that might lessen this burden, in the main, fruitlessly. Dr. Evans argues that there have been no suits in the United States in this regard up until now. I agree, but I remind him that when I entered practice in 1941, malpractice suits were a rarity but suddenly lawyers found this a very interesting and profitable field. Now it is becoming an increasingly great jeopardy for doctors. We legislators in Florida have removed a great source of income to lawyers with the passage of the no-fault divorce and no-fault auto insurance. As they look to the malpractice field, isn't it plausible that they will look to the field of death as a new and fruitful territory to explore? Or am I completely wrong, Dr. Evans?

▶ Dr. Sackett, 2500 Coral Way, Miami 33145.

Death and Dying

Not uncommonly, in spite of every medical effort the balance in an acutely ill individual tilts toward death. The emergency of death can strike like a bolt from the blue as in acute poisoning, or in acute pulmonary oedema, or in an acute fulminant infection. The doctor sometimes has to wait in agony, watch in despair, and stand and stare in helpless impotence as his effort turns to nought and as the inevitable end draws nigh. The emergency of death can also be the merciful end to a chronic painful incurable disease, as in a patient with advanced cancer, or in a patient with intractable chronic respiratory failure. Finally the doctor may witness an emergency, which in fact is the natural and merciful end to extreme senescence, when life processes ebb imperceptibly into death. He must learn to face this emergency with compassion, calm and philosophy; he must be able to impart his calm and philosophy to the dying patient and to his anguished relatives.

Dying can be very difficult and at times very painful, and many a patient will refuse to realise or admit to himself that he is close to death. It is after all quite impossible for another person to share or exactly experience the feelings and the thought processes of a dying man. As Pascal said, "On mourra seul,"—one dies alone. Let every doctor respect the gravity of death in whosoever it occurs, if only because it is the way of all flesh, if only because it is bound in time to come to touch him and those near and dear to him, if only because it is a constant illustration of the limitation of his science. Let the doctor learn to lighten the loneliness of death. This he can only do by acquiring qualities and requisites which cannot be ascertained or detected by scientific methods. To quote A. R. Feinstein, "with them he can often give healing and comfort where science fails or does not exist. Without this his science is unsatisfactory no matter how excellent."

F. E. Udwadia, Reprinted from *Diagnosis and Management of Medical Emergencies,* Rustom Jal Vakil and Farokh Erach Udwadia, Bombay, India, 1973, p. 5.

Continuing Education for the Physicians of Florida

MICHAEL J. PICKERING, M.D.

We all consider that we are educated: In medical school, we learned how to study and attain the knowledge required of us. Most of us are still students in an attempt to "keep up" with the explosive progress in medical science. Most of us realize that we cannot read "all" of the journals, "all" of the text books, nor attend "all" of the meetings . . . yet we try.

We are being besieged by medicolegal persons, telling us "average medical care manifested in the community is not enough." This was settled in a court case in Massachusetts. The decision was, "A physician shall be as competent as his peers anywhere." Our consumer representative, Ralph Nader, in his treatise, "An Inquiry into the Profession's Performance in Self Regulation," was certainly derogatory. New Mexico, Maryland, Oregon, and Pennsylvania have all demanded continuing education in their states. New Mexico and Maryland have done so by the state legislature route and require it for licensure to practice in the state. Recertification is rapidly taking hold. The American College of Physicians is offering the first "voluntary" test for relicensure this fall, for those physicians licensed prior to 1968.

The American Osteopathic Association, in June 1973, made continuing education mandatory for membership. The Joint Commission is demanding evidence of continuing medical education by hospitals for accreditation. Implicit, in the PSRO regulation, is quality of medical care.

All of this led to the physicians in the State of Florida seizing the initiative and voting, via the House of Delegates, in May 1973, to require continuing medical education for maintenance of membership in the Florida Medical Association. The House then directed the Committee on Continuing Medical Education to develop a mechanism of implementation. The committee has attempted to do this. This committee is as follows:

Michael J. Pickering, M.D., Chairman, Lakeland
E. Eddy Burns, M.D., St. Petersburg
Herbert A. Burke Jr., M.D., Jacksonville
Lamar E. Crevasse Jr., M.D., Gainesville
Thornton A. Beckner, M.D., Orlando
John E. Cunio, M.D., Miami
Jack W. Hickman, M.D., Tampa
Henry M. Yonge, M.D., Pensacola
T. Vernon Finch, M.D., Sarasota
Sidney Blumenthal, M.D., Miami
Pat B. Unger, M.D., Melbourne
Lynn P. Carmichael, M.D., Miami
Max Michael Jr., M.D., Jacksonville
Mr. John McBryde, Orlando
Francis C. Coleman, M.D., Tampa
Mr. Robert P. Lawton, Sarasota
Clifford R. Guy, M.D., Jacksonville
Thomas E. McKell, M.D., Tampa—Ex officio

As one can readily perceive, the presidents have been wise in providing a broad-based and representative committee. These men have, thus far, given of their time, energy and minds, both freely and cheerfully. They have all answered the request of the president to serve and none, that I am aware of, were actively seeking such a task.

What has the committee done? We have established the criteria for continuing medical education, as follows:

(1) Ninety (90) hours of continuing medical education within a 3-year period will be required for maintenance of regular active Association membership. All of the hours may be obtained in any one year.

(2) The American Medical Association's Physician's Recognition Award and the American Academy of Family Physicians Certificate of Education will be acceptable for fulfilling the regulation. As other certifications are developed, they will be considered for acceptance by the Committee on Continuing Medical Education.

(3) Extenuating circumstances preventing an individual from obtaining the required hours of continuing education will be considered by the Committee on Continuing Medical Education.

(4) Hour for hour credit will be given for participation in an acceptable course or as stated for that program.

Dr. Pickering is Chairman, Committee on Continuing Medical Education.

(5) Hours required for maintenance of membership will be classified in the following manner:

A. Mandatory hours (at least 60 hours)
   a. Fifty (50) credit hours will be allowed for a full year of internship, residency, fellowship or research.
   b. Postgraduate courses approved by the FMA, AMA, or AAFP and/or those sponsored by medical schools.

B. Elective hours (no more than 30 hours) credit will be given for participation in scientific hospital meetings, county medical society meetings and personal continuing education activities such as listening to tapes, journal clubs and library reading on an hour-for-hour basis. Such activities must be listed as to time and title. Evidence of registration in meetings must be presented whenever possible.

We have just finished preparing the form for each physician to record his continuing medical education hours. At present, the desire is to have the individual societies keep track of and certify their member's compliance with the standards. There has been much discussion concerning the individual societies' performing this as some feel that they are not adequately staffed to handle such a job. This is especially true of the larger county societies. We, of the committee, have tended to agree with that philosophy; therefore, we have an alternate proposal prepared and have recommended to the Board of Governors of the Florida Medical Association that we proceed with it. This method of documentation is thought to be easier and consists of each member having a card, similar to a credit card, with the pertinent data on it. All he need do is present it to the registrar at whatever meeting he attends and he would receive a copy for certification. Another copy would automatically then go to the FMA office in Jacksonville for compiling. In this way, the individual physician has the opportunity to ask for his total accrued hours at any time. This would also allow for better documentation, should any agency ever require it.

Pertaining to documentation, it is certainly pertinent that in 1973, a Bill was being considered which would have created legislation requiring a physician in the State of Florida to continue medical education for relicensure.

The Committee explained the Florida Medical Association's progress in this field to the individual who was considering the legislation and he accepted it very well. The committee was aided in this endeavor by the honorable Representative F. Eugene Tubbs, and at this time they are waiting and watching to see how our self-regulating, self-imposed system proves itself.

What are we planning to do? Your committee is presently attempting to develop criteria that will comply with the American Medical Association standards and be acceptable to the Florida Medical Association standards for an accrediting program within the state. We have thought, from the beginning, that if the physicians require continuing education of themselves, they should have quality education where it is most convenient and most relative. That place is where each physician works. We are receiving a number of requests for accreditation at the present time. We have asked the Board of Governors for permission to pursue this course and they have given their endorsement. We fully realize the vast amount of time and effort that this will entail, but someone has to do it and we are the most logical agency.

Therefore, your Committee on Continuing Medical Education is attempting to carry out your orders and we certainly hope our efforts meet with your approval. This is where we are at present and this is the way it appears we will be going.

▶ Dr. Pickering, Watson Clinic, Lakeland, Florida 33802.

In every true searcher of Nature, there is a kind of religious reverence; for he finds it impossible to imagine that he is the first to have thought out the exceedingly delicate threads that connect his perceptions. The aspect of knowledge which has not yet been laid bare gives the investigator a feeling akin to that experienced by a child who seeks to grasp the masterly way in which elders manipulate things.

Albert Einstein

RX For Prandial Pleasures

Richard and Lenore Fleming

Editor's Note: Again this year, Dr. and Mrs. Fleming researched "good eating places" in the area of the annual meeting in order to make your visit to Hollywood more enjoyable.

Just as no prescription is universally applicable to all patients, no recommendation for food would appeal to all palates. You might have your own favorites—if not, here's an abbreviated gastronomic pharmacopoeia of the lower Gold Coast which you might find helpful in choosing a place to dine.

Rising prices are on the menu this year. As a matter of fact, prices are rising so rapidly that in one restaurant we visited, a notice on the menu suggested that the patron consult the waiter for the current price of any item! (This happened in Washington, not Miami Beach, but I'm sure it can happen any place). All we can say is that the "relative value scale" applies to most of the places listed but the whole scale should be moved up a notch or two from last year.

Obviously, we have not listed all of the good restaurants here, so if a friend recommends a really good eating place, don't hesitate to accept his advice provided you trust his taste! Better still, this tip—if a "local" invites you out to dinner and asks if you have a choice, suggest that he take you to his club if he has one. Some of the best dining in the area is in the private clubs of which there are many. They are usually more intimate, and relaxed, in addition to having fine food and the best service.

Hollywood—Fort Lauderdale Area

CELEBRITY ROOM, DIPLOMAT HOTEL—this is an elegant room, with music and dancing, French cuisine: the veal Oscar is excellent. Phone: 923-8111. Expensive.

DOWN UNDER: 3000 East Oakland Blvd., Ft. Lauderdale—564-6984. Attractive and unusual decor, located literally "down under a bridge" on the intercoastal waterway. Large variety of delicious food tastefully prepared and interestingly served. Moderate.

LE DOME OF THE FOUR SEASONS: 333 Sunset Drive, Ft. Lauderdale—525-3303. Continental cuisine; excellent. Magnificant view worth visiting for this alone! Expensive.

CLIPPER ROOM at YANKEE CLIPPER: 1140 Seabreeze Blvd., Ft. Lauderdale. (A1A) 524-5551. Excellent continental cuisine; intimate, charming. Moderate to expensive.

BENIHANA OF TOKYO: JAPANESE STEAK HOUSE: 4343 Trade Winds Avenue, Lauderdale by-the-Sea. 566-1569. Beautiful Japanese style architecture and landscaping on the inland waterway. The steaks and vegetables are cooked on a hibachi surrounded on three sides by a table while the chef on the fourth side performs magic with his knife as he slices and flips the steak. The meat is marvelous—said to be Kobe (Japan) beef—from cattle pampered on beer. Two slight faults—unless you come with a party of 8 you'll share a table with strangers since all tables are for 8 and the place is always busy. Secondly, I detected on one visit a sense of "super-efficiency" which bordered on commercialism. For instance, before we were finished eating, the chef had cleaned the hibachi and brought in a new stack of dishes—a gesture I missed on the first round! Despite this, we recommend that you try it for you will certainly like the food.

A new Benihana has been opened on 79th Street Causeway, Miami (1665 Kennedy Causeway) 866-2768, larger, with more cement and less charm than the one in Fort Lauderdale. Everything we said about B.H. of Fort Lauderdale applies. It is an experience, the food is excellent, but leisurely dining in privacy it is not.

Hallandale and Upper Miami Beach

MANERO'S RESTAURANT: 2600 East Beach Blvd. 923-1661. Steaks and Italian food; known for cheese salad. Very popular; usually overflowing. Moderate.

GRIST MILL: 19400 Collins Avenue. 947-2676. In the Sheraton Beach Resort Hotel on the ocean. And it is a grist mill—an attractive replica, that is! American cuisine; large menu. Everyone seems to enjoy this one. Moderate.

CHRISTINE LEE'S GAS LIGHT—in the Golden Strand Hotel—at 17901 Collins Avenue. 945-9075. An unusual Chinese restaurant that features outstanding Chinese and American food. Their Sirloin is prepared with a delicacy of flavor that ranks with the best we've had. And no wonder—we are told that Christine's is the sole outlet in the area for a large Colorado beef distributor. The Chinese dishes are interesting, tasty, well prepared and hot—currently our favorite place for Chinese food. Moderate.

THE RED COACH GRILL: 1850 Collins Avenue—949-5461. This is a welcome addition in this area. There are two other locations. In Miami, 1455 Biscayne Boulevard—379-4008. In Ft. Lauderdale, 1200 North Federal Highway—1-564-0432. Consistently good food. Large squares of butter and delicious breads their trademark. Caesar's salad at no extra charge is delicious. Maine lobsters when available are the best we've ever had. The steak sandwich is usually good and is a meal in itself. Inexpensive—moderate.

Bal Harbour—Bay Harbour

GAUCHO ROOM, AMERICANA HOTEL. The Gaucho Room has always been a favorite with FMA members, and if you haven't eaten there before, you certainly should. The steaks are great, as are the other meats. Moderate—expensive. 865-7511.

DeCONTINENTAL: 1045 — 95th Street. 865-8224. French-Italian dishes. Elegant setting. Expensive.

POST & PADDOCK: 9650 E. Bay Harbor Drive, Bay Harbor Island. 866-8706. American cuisine; steaks, seafood. Old standby. Small version of 21 Club in New York. Moderate—expensive.

CAFE CHAUVERON: 9561 E. Bay Harbor Drive, Bay Harbor Island. 866-8779. A welcome addition to the area's constellation of great restaurants. This well known New York restaurant moved into the old Tony Sweet's location, refurbished it completely to make it one of the most elegant, plush and expensive places here. Chiefly French cuisine; excellent. Expensive.

Miami Beach

THE BETSY—in the Flamingo Hotel, 5875 Collins Avenue. 861-9000. A very unusual and most attractive restaurant with an indoor-outdoor garden setting planned around the whimsical Betsy Tree, which changes with the seasons. Excellent American cuisine served with a flair. Expensive.

BERNARD'S—5401 Collins Avenue, in the Carriage House Apt. Hotel. 864-4804. Small, plush, quiet. Continental cuisine. Menu limited but excellent. Bernard is no longer there but I am told that they are carrying on in the same tradition. Expensive.

EMBERS: 245-22nd Street, 538-4345. Famous for hickory cooked steaks, ribs and chops as well as pheasant and other fowl. Always popular. Moderate—expensive.

GATTI'S: 1427 West Avenue. 673-1717. One of the oldest and best restaurants on Miami Beach. Italian with continental flair. Veal dishes outstanding. Joe Gatti will charm you. May be closed; be sure to call. Moderate-expensive.

JOE'S STONE CRABS: 227 Biscayne Street (near the Southern tip of Miami Beach). 637-0365. A landmark. No one wants to miss this one —marvelous stone crabs (cold, of course), hot drawn butter, hash-brown potatoes and the secret formula coleslaw washed down with Heineken's beer. No reservations and you will find a large crowd waiting, unless you come before 6:30 or after 8:45. Moderate-expensive.

LE PARISIEN: 474 Arthur Godfrey Road (41st St.) 534-4770. Small, chic, French cuisine of high quality. Try Duck a L'Orange if you like duck. Expensive.

OLD FORGE: 432 Arthur Godfrey Road (41st St.) 534-4536. Site of old blacksmith shop in the days when there was a polo field up the street off Arthur Godfrey Road. We used to enjoy dining in the open patio around the tree where originally the horses were shod and where later St. Gaudens, the sculptor, had his studio upstairs. But alas, progress has pulled the tree down and converted the patio to another room. Interesting decor however. Wander through the old fashioned bar for a look at the art but get a table for dining as far away as possible or you'll be blasted out of your seat when the rock band starts! Excellent steaks and chops. Usually crowded but the service is good. Open late. Moderate-expensive.

OMAR'S TENT: 534 Arthur Godfrey Road (41st Street) 532-8422. Small and unpretentious place with variety of excellent Syrian-Lebanese foods. The Kibbi Tartare and Tabooley salad are excellent side dishes but can be a meal in itself. Desserts are mouth-watering. The Turkish coffee is "mud" but we like it. Inexpensive-moderate.

THE PUB AT THE RONEY—2301 Collins Avenue. 532-3353.

We have never forgiven them for demolishing the old Roney Plaza—so many fond memories, but the Pub in the new Roney goes quite a way to compensate for the loss. A large but comfortable room with open hearths, attractive appointments, good food, especially roast beef. There's always a waiting line, however. Moderate.

The PUB AT THE NEWPORT—16701 Collins Avenue. 949-7433—is the same but somewhat smaller.

79th Street Causeway

NICK AND ARTHUR'S: 1601—79th Street Causeway. 866-9759. Excellent food; American cuisine; steaks, stone crabs. Large and somewhat bustling. Good service. Moderate-expensive.

MIKE GORDON'S: 79th Street Causeway on the Bay at Miami side. 759-6825. Old reliable seafood place; Red Snapper a specialty. Moderate.

North Miami

CASA SANTINO: 10999 Biscayne Blvd, Miami. 895-1440. Real Italian—none better. Very popular. Moderate-expensive.

CATTLEMAN: 1800 N. E. 124th St., Miami. 891-1600. Plush 1890's decor with 5 or 6 rooms decorated differently—be sure to see them all. Good food—American. Complimentary wine, liqueurs and cigars with steaks. What more can one ask? Although crowded and somewhat commercialized, it's worth a visit for the atmosphere. Moderate.

PORT OF CALL—11411 Biscayne Blvd. 945-2567. A relatively new seafood restaurant that has become quite popular and deservedly so. Operated by Robert Trobridge and William Beck, a former charter boat captain, they have the advantage of knowing what fish are best at what particular time and how to get them. Any of their offerings are good and you know they're fresh. Moderate.

MARCELLA'S LA CUCINA MIA—13800 W. Dixie Highway, North Miami. 891-8220. Italian cuisine, nine courses, served in a "wine cellar." You take what the chef decides to serve that particular evening, but don't worry, it's all good. It will take about three hours to go through the whole dinner, so don't plan anything else that evening! Marcella's caters more large, important affairs than any other restaurant in the area. If the entire FMA descended on the restaurant she wouldn't be fazed—she'd probably set up a tent or two and serve the most memorable meal the Association ever had! (We had such an experience at the Hialeah Race Track one evening.) Expensive—($13.50 complete dinner).

GOLDEN GREEK—12500 Biscayne Blvd. 893-1177. Good Greek food and wines in a relaxed atmosphere. The waiters and waitresses put on a miniature floor show of Greek dancing, which is popular with the customers. Inexpensive to moderate.

Dania (3-4 miles north of Hollywood)

LA NORMANDIE—129 N. Federal Highway, Dania. 927-1889. A delightful French "family affair" operated by Nora Fredy. Husband Charles is a registered certified sommelier, who, when not busy as a representative of a well known wine and spirit import company, assists in the preparation of unusual desserts, as well as taking care of your wine needs. Brother Andre is a well known chef whose offerings delight even the most demanding gourmets. Specialties: Sweetbreads, steak au poivre, duckling. Moderate.

Miami

PRINCE HAMLET DANISH RESTAURANT: 8301 Biscayne Blvd. 757-5541. An outstanding restaurant with that wonderful Copenhagen charm and decor. Tables, chairs, baby carriages, etc. suspended upside down from the ceiling—the pixyish Danish sense of humor—rough hewn interior, costumed waiters and a friendly atmosphere so typical of Denmark. The complimentary seafood bar has everything imaginable including caviar and one must be careful not to make a meal of it here, for the best is yet to come. Bouillabaisse, fish, steaks—all tastefully prepared and, oh yes—be sure to go Danish all the way by downing a thimbleful of aquavit (is permitted to chase with beer p.r.n.) Skoal! Always crowded—even with reservations there is a wait unless you come early but it's worth it. Moderate.

CAFE LES AMBASSADEURS: In the Sheraton Four Ambassadors: 801 S. Bayshore Drive. 377-1966. French cuisine. Elegant dining in a plush cuisine. Strolling violins; steaks flamed

at table. Steak au Poivre great if your stomach mucosa is in reasonably good condition. Crepe Suzettes and Cafe Don Juan prepared by the Maitre d' with a flourish. Moderate-expensive.

PICCADILLY HEARTH RESTAURANT: 35 N. E. 40th Street. 751-1818. Located in the midst of Decorator's Row. (The ladies in particular will enjoy strolling thru this unusual street). Small, charming, elegant English Pub decor. Delicious food with daily specialties; equally good for lunch. Veal dishes outstanding. Moderate.

VIZCAYA RESTAURANT: (No connection with Vizcaya Art Museum): 2436 S. W. Eighth Street. 642-9022. Spanish-Basque cuisine. Large selection; delicious; crowded and lively. Flamboyant decor. Moderate.

CENTRO VASCO: 2235 S. W. 8th Street. 643-9606. Like the Vizcaya; Spanish-Basque. Seafood, steak madrilene a specialty. Can't go wrong with either of these. Moderate.

LES VIOLINS, INC.: 1751 Biscayne Blvd. 371-8668. Operated by group of Cuban expatriates, all of whom work as waiters, cooks, managers, etc. The waiters double as entertainers (they're good too!). Moderate.

FLAMENCO SUPPER CLUB: 991 N. E. 79th Street. 751-8631. Same as above with same operators.

Coral Gables

CHEZ VENDOME: 700 Biltmore Way, Coral Gables. 443-4646. An intimate version of the Cafe des Ambassadeurs. French cuisine equally as good and served with the same flair. Moderate-expensive.

SPARTA—394 Giralda Avenue, Coral Gables. 448-1551. Tucked away in the middle of Coral Gables this family-style Greek restaurant has long been a favorite with the local gendre. They were selected to cater a back-stage supper for Maria Callas after her recent performance in Miami. You'll have trouble finding this one on your own—ask a Coral Gable-ite. No wine or liquor served. Ask if you may bring your own.

Miami Springs

JAPANESE STEAK HOUSE: 500 Deer Run. 871-6000. Pretty girls in kimonos prepare your beautiful steak Japanese style where you sit; either at a floor table or conventional table. A tasty treat and delightful experience. The homeopathic servings of Sake are just right. Moderate-expensive.

KING ARTHUR'S COURT: 500 Deer Run. 871-6000. Huge, high-ceilinged room with ornate Medieval decor attractively done. You guessed it —Beef is the favorite and the prime ribs are the best. No reservations—usually a wait, especially on weekends. Moderate-expensive.

Key Biscayne

JAMAICA INN RESTAURANT: 320 Crandon Blvd. 361-5481. Spacious, with enclosed tropical garden. American cuisine; Roast Beef a specialty; frog legs, steak, etc. Moderate-expensive.

THE ENGLISH PUB: Next door to Jamaica Inn. 361-5481. Copy of an English Pub and most attractive. Informal. Be sure to look at the various rooms. Menu similar to above. Moderate.

Be sure to call for reservations—most places require it (two or three exceptions). Although we have checked most of them as to closing dates for the season, this sometimes changes and you might save a trip by making a call. Get a map and directions before setting out—it will save you time!

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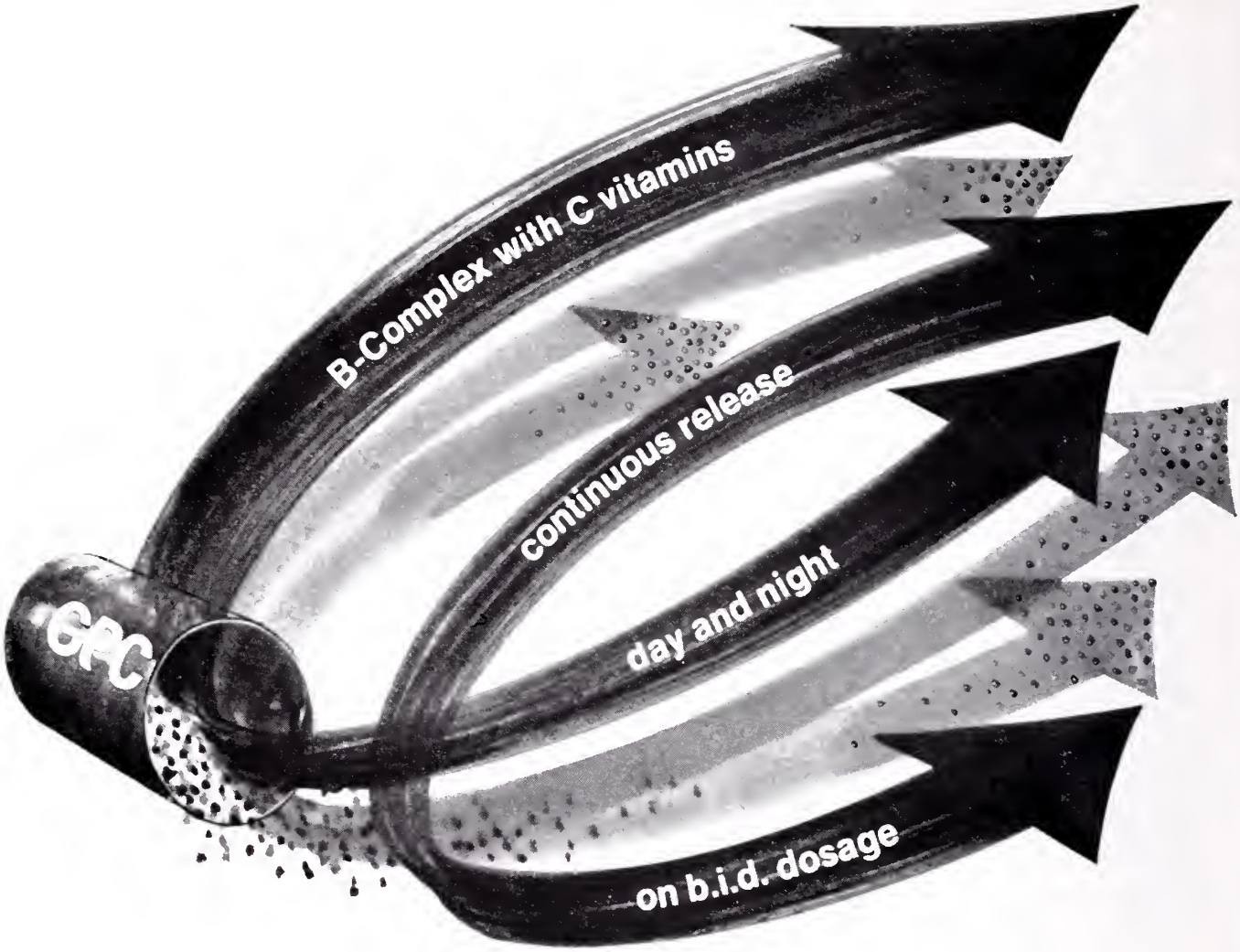

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Use of Immunosuppressant Drugs in Nonneoplastic Disease

JACQUES R. CALDWELL, M.D.

Abstract: Criteria and a rationale for use of immunosuppressant drugs in nonneoplastic disease are presented. Cyclophosphamide appears to be the agent best suited for suppressing antibody formation. Azathioprine has been shown to be effective as an inhibitor of cellular immune mechanisms. Antimitotic drugs such as azathioprine and methotrexate effectively inhibit disease states, such as psoriasis, which are characterized by rapid turnover of cells. All immunosuppressant drugs are toxic — even in recommended doses and their use should be reserved for those patients whose disease is potentially reversible, which is life-threatening or severely disabling, and which has not responded to conventional therapy. The patient must be free from infection or hematologic abnormalities, must be willing and capable of obtaining careful laboratory and clinical followup, must be fully informed of the potential dangers of these agents.

The use of immunosuppressant drugs for the treatment of patients with illnesses caused by a presumed immunologic mechanism has enjoyed increasing popularity during the past several years. However, control studies concerning the efficacy of these drugs are sparse and toxicity from their use is severe. The purpose of this communication is to review the pharmacology, toxicology, and efficacy of immunosuppressant drugs in nonneoplastic disease and to provide a rationale for their appropriate utilization. Discussion will be limited to those three compounds which have been most extensively studied—azathioprine, cyclophosphamide, and methotrexate.

Azathioprine and methotrexate are antimetabolites which interfere with DNA synthesis and thus impede cell replication. Azathioprine is a purine analog and blocks nucleic acid synthesis and interconversion of nucleotides. Methotrexate inhibits the enzyme dihydrofolic acid reductase which ultimately impedes incorporation of one-carbon fragments into DNA and into certain amino acids. Cyclophosphamide is one of the alkylating agents—a group of compounds capable of broad spectrum interference with cellular metabolism. These agents cross link protein to nucleic acids, thereby altering nucleic acid function; they impede mitotic division and interfere with certain intracellular enzyme systems.

Information concerning the effect of these three compounds on the immune system is difficult to cull from the literature because studies vary so widely with respect to drug dosage, to frequency of drug administration, and to animal species. Azathioprine and cyclophosphamide are administered in total daily doses of 2-3 mg/kg; methotrexate is given in a dose of 0.05-0.1 mg/kg per day. There is evidence that this dosage regimen in man identifies different effects of azathioprine and cyclophosphamide on the immune response to a particular antigen. Cyclophosphamide best inhibits antibody synthesis. Azathioprine is a more potent inhibitor of cell mediated immunity.[1]

Most of the immunologically related diseases which we treat with immunosuppressant agents are immune complex disorders, i.e., circulating complexes of antigen and antibody which deposit in the interstices of endothelial surfaces, fix complement (thereby generating chemotactic factors), attract polymorphonuclear leucocytes to the site

of the immune complex entrapment, and thus stimulate a marked inflammatory response. The polymorphs attempt to ingest the immune complexes and in the process release lysosomal enzymes which destroy local tissue. This process can best be prevented by inhibiting antibody synthesis to the antigen responsible for the disease. Cyclophosphamide best accomplishes this and is useful in the treatment of immune complex disorders such as lupus nephritis and rheumatoid arthritis. Cyclophosphamide therapy results in the removal of immune complex deposits from renal glomeruli of patients with lupus nephritis. In contrast, azathioprine, methotrexate (or steroid) treatment does not eliminate these complexes from kidneys of patients with lupus nephritis.[2] Use of azathioprine, methotrexate, and steroids may improve renal function in these patients but does not alter the underlying factors responsible for the disease, viz, the immune complexes. In immune complex disease, their action is antiinflammatory and not immunosuppressive. Cyclophosphamide therapy for rheumatoid arthritis halts progression of bony erosions and joint destruction[3]; steroids, in contrast, permit the underlying destruction to progress relentlessly. Azathioprine will decrease inflammation in joints of patients with rheumatoid arthritis, but no evidence exists which indicates that it induces remission of the underlying joint pathology. Cyclophosphamide is probably the immunosuppressant of first choice in patients with immune complex disorders.

Immunosuppressants have been used with various degrees of success in other diseases. Controlled studies are not available concerning their use in membranoproliferative glomerulonephritis from conditions other than lupus. Recently, one study demonstrated that the combination of azathioprine, cyclophosphamide and prednisolone had superior theropeutic benefit in membranoproliferative glomerulonephritis than did any two drug combination or single drug regimen.[4]

These agents have been used in a variety of gastroenterologic disorders. Azathioprine has a steroid sparing effect when used in the treatment of chronic active hepatitis but azathioprine alone is no better than placebo.[5] Azathioprine has some success in the treatment of regional enteritis.[6] Rejection of organ transplants is dependent upon the cellular immune mechanisms and azathioprine, which impedes cell mediated immunity, has become the drug of choice in preventing such reactions.

Methotrexate and azathioprine are potent inhibitors of cell mitosis which renders them effective in the treatment of psoriasis—a disease characterized by marked turnover of epidermal cells.

Uncontrolled studies have suggested that immunosuppressants are helpful in Wegener's granulomatosis,[7] in steroid resistant autoimmune hemolytic anemia,[8] and in steroid-splenectomy resistant idiopathic thrombocytopenic purpura.[9]

Toxicology

The immunosuppressant drugs are severely toxic. Use of any of them markedly increases the risk of infection. In Starzl's review of 189 transplant patients, 79 died. Infection was a contributing factor to the demise of three quarters of these recipients.[10] Frequently exotic microorganisms such as gram negative bacteria, viruses, mycobacteria, fungi, and pneumocystis carinii caused the lethal infection.

A markedly increased risk of a neoplasm has been associated with the use of immunosuppressants, particularly azathioprine in recent years. In one study a tumor developed in 7% of all renal transplant recipients who had taken this drug for over four months. The incidence in a group of matched controls was .06%.

All these drugs suppress the bone marrow and can produce thrombocytopenia, leukopenia or anemia. Also, all are teratogenic and must not be used in women who are pregnant or susceptible to pregnancy.

Individual agents also have unique toxic side effects. Cyclophosphamide induces hemorrhagic cystitis which occasionally may be life threatening in 30% of recipients. This effect is produced by a direct toxic action of a metabolite on the bladder mucosa. Consumption of large quantities of fluid and frequent voiding is mandatory to reduce the risk of this complication. Ovarian failure, amenorrhea, aspermia and even permanent sterility may complicate the use of cyclophosphamide and to a lesser extent the other immunosuppressants. A reversible alopecia also appears with this agent and is psychologically quite distressing to many individuals.

Methotrexate can produce portal fibrosis, reactive hepatitis, and cirrhosis; it is recommended that prospective recipients undergo a liver biopsy to rule out underlying pathology before employment of this drug.

Azathioprine can produce a precipitous granu-

locytopenia, even in patients who have been receiving the drug for prolonged periods.

Immunosuppressant agents are ameliorative and not curative. They are exceedingly toxic and/or have the potential of creating a life threatening complication such as an untreatable infection, a tumor, or an uncontrollable hemorrhagic cystitis. The decision to use one of these agents must be made after the physician has determined that the disease will render more harm to the patient than the drug.

Criteria for use of these compounds have been proposed and their application can guide the physician in their use (Table 1).[11] First, the patient must have a life threatening or potentially severe disabling condition. Their use, therefore, in mild to moderately severe rheumatoid arthritis would not be warranted. Second, the patient's disease must be reversible, Thus, the patient with severe deformity from rheumatoid arthritis whose joints have been destroyed and no longer has active synovitis is not a candidate for their use. Third, the disease must be either unresponsive to conventional modes of therapy or conventional therapy is unacceptable because of noxious side effects. These drugs are to be reserved therefore as a desperate last choice in the treatment of these conditions. Fourth, the patient must be free from active infection since these agents can compromise host defenses against infection. Fifth, the patient must be free of hematologic abnormalities since these compounds suppress the bone marrow. Sixth, the patient must be cooperative and available for follow-up.

TABLE 1.—CRITERIA FOR USE OF IMMUNOSUPPRESSANT DRUGS IN NONNEOPLASTIC DISEASE.

1. Life threatening illness
2. Reversible disease
3. Unresponsive to conventional therapy
4. Patient has no evidence of infection
5. Patient has no evidence of bone marrow suppression
6. Patient available for follow-up
7. Physician has adequate laboratory back-up for following patient
8. Informed consent-drugs are experimental
9. Patients studied on protocol approved by institutional peer review

Long term utilization of these drugs without follow-up can be lethal. Seventh, the physician must have adequate facilities available to him to follow the patient appropriately, i.e., he must have a microbiology lab capable of identifying fungi and certain other bizarre organisms which may appear in patients treated with these compounds; he must have a responsive lab which can rapidly notify him of severe changes in any functional parameter. He must have access to someone who can perform and interpret bone marrows, liver biopsies, etc. Eighth, the patient must be fully informed of the hazards presented by these drugs and must sign an informed consent release. Ninth, the use of these drugs should be limited to a protocol which has been critically reviewed and approved by an institutional peer review committee. These drugs have not been approved by the Food and Drug Administration for treatment of nonneoplastic disorders and the last two criteria should be met to satisfy the FDA's requirement for use of drugs in an experimental study.

In summary, the immunosuppressant drugs have been shown to be useful in the treatment of certain nonneoplastic disorders but their use is hazardous to the patients and must be tempered by fulfillment of certain well defined criteria.

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FEEDBACK - from Pearl Street

Florida's Immunization Law

The current school term is the third since Florida's Compulsory Immunization Law was passed. The law requires that children must present evidence of full immunization, or an individual religious or medical exemption before being admitted to kindergarten or first grade. All public and private elementary schools and kindergartens are required to furnish a report summarizing the immunization status. This year 210,637 children are included in the reports submitted, an increase of almost 15,000 over 1972-73. Of all kindergarten and first grade students 86.1% are fully immunized against diphtheria, whooping cough, tetanus, polio, measles, and rubella. This is an increase of almost 14,000 over the previous year. Additionally, 18,564 children are enrolled with individual medical exemptions. This is interpreted to mean that these children have had all the vaccines which could have been given in accordance with accepted medical practice up to the time they were enrolled. In most cases the immunization levels in kindergartens and first grades are estimated to be 90% or greater. The table compares the levels of kindergarten and first grade immunization reported since 1971.

Reported Status of Kindergarten and First Grades

Florida 1971-1973

School Year	Number of Schools Reporting	Number of Children Enrolled	Per Cent of Children Fully Immunized*
1973-74	2,076	210,637	86.1%
1972-73	1,890	195,644	81.5%
1971-72	1,351	158,540	50.8%

* Fully immunized children must have had 4+ DPT doses, 3+ OPV doses, 1 dose measles vaccine, 1 dose Rubella vaccine.

These improved immunization levels are paying dividends by reducing disease morbidity and mortality. Throughout the 1972-73 school year and so far this year, there have been no documented outbreaks of measles or rubella in Florida's elementary schools. Only 391 measles cases were reported in 1973, the fewest number ever.

The benefits accruing from compliance with the Compulsory Immunization Law in reducing morbidity have been amply demonstrated. The potential hazards of not complying were rather dramatically demonstrated this year by an outbreak of three cases of diphtheria in one elementary school. The children were members of the same family and all had been admitted to school without any immunizations. Fortunately there was no spread to other children.

Failure to immunize boys against rubella may constitute another hazard. Since rubella is generally a mild disease, some physicians believe that the use of rubella vaccine for boys is not indicated. Vaccination of children for rubella is, however, aimed primarily at prevention of congenital rubella syndrome resulting from maternal transmission of the virus to the fetus during the first trimester of pregnancy. If boys are admitted to school without rubella immunization through individual medical exemptions, elimination of the classroom as a reservoir for the spread of rubella cannot be achieved, and teachers who become pregnant would be most susceptible to rubella outbreaks occurring in the classroom. Since rubella vaccine is not medically contraindicated for boys this may raise a question of liability.

The physicians, nurses, county health departments and schools who have cooperated and worked hard to implement the guidelines and requirements of the compulsory immunization law have indeed performed a real public service. The 95% of the parents who have had their children immunized have also done their part. The majority of those unimmunized are enrolled in a handful of schools and counties.

Through the application of the law the immunization levels in Florida have reached an historic high with concurrent reduction in vaccine preventable diseases. Continuing efforts on the part of all—physicians, nurses, county health departments and schools—are essential to assure that these difficultly achieved levels do not gradually erode.

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Editorials

First, Do No Harm

Senator Kennedy commented on the pharmacological education of American physicians in a recent article in one of the pharmaceutical industry publications. As might have been expected, he low-rated us. He quoted a study that reported that 62.5% of physicians stated that they could not keep up with new drug information. Presumably, the .5% represented a man who half tried to keep up with the literature. He further indicated that 75% of these physicians spend less than two hours per week obtaining new drug information. Finally, he decried the dependence of American physicians on the drug detail man as the source of information on new pharmaceuticals.

He advocated a three-pronged approach to the resulting problem. First, the pharmacist should know the reason for each prescription. Second, he/she should make sure that the patient knows what he is taking. Finally, he/she should instruct the patient how to take the medicine. These last two recommendations are dynamite. As one who has marked his prescriptions "label" for many years, I have just learned how avant garde I have been. This other new technique in which the pharmacist writes on the label: "Take one tablet before each meal and at bedtime" will probably sweep the country now that the Senator from Massachusetts has suggested it. And they say we are not getting any leadership from Washington!

The proposal that the pharmacist "know the reason for each prescription" is something else again. On many occasions, each of us has sought some information on materia medica from the pharmacist with great assistance. He is only too willing to help as a fellow professional. This recommendation, however, has obvious limitations. The pharmacist simply does not have the medical background to fully evaluate the indications for a given prescription. His knowledge of the patient and the pathophysiology of disease is inadequate to become a judge in such matters.

From the practical point of view, picture in your mind the average drugstore. Robert Wilson, our harried pharmacist is busy trying to decipher the writing of Dr. Illegible. At the counter, several impatient customers are waiting to have their prescriptions filled. Mrs. Jones wants to get her prescription filled without seeing the doctor again. Mrs. Smith wants to know if it is really true as they say on TV that most doctors recommend milk of magnesia over the bulk or stimulant laxatives. His clerical help may be badgering him about which hair spray is on sale or whether the 1¢ sale begins today or tomorrow. This is a man on the verge of an acute anxiety reaction.

At this point, the phone rings and his assistant tells him that Dr. Kramps wants to speak with him. Dr. K tells him that he has ordered a prescription for Valium for Mrs. Brown. Her son was just arrested for siphoning gas for his motorcycle from the Chief of Police's car. The medication is to help her relax. He hangs up and on the other line Dr. Zonk relates that he has ordered an antibiotic for his patient who contracted a social disease while on vacation in Tiajuana. This call is followed by another physician who is ordering cough medicine because his patient has bronchitis. About this time, the pharmacist's comments to the physicians would start melting the wires.

The above assumes a one physician to one pharmacist ratio. This may be true in Toonerville, but this obviously is not true in Miami, or Tampa, or Orlando. Discovering which pharmacy to call would require the full time of one office clerk. While this might help the unemployment situation, it has little else to recommend it. Meanwhile, at a busy pharmacy, you would have doctor after doctor on hold waiting to tell the pharmacist the reason for each prescription. It is the

sort of situation that one would expect in an Art Buchwald satire.

There is a valid point to be made for the necessity of the physician to remain current on those drugs which he prescribes. It is not necessary for a psychiatrist to be aware of the detailed use of pentamidine isethionate in the treatment of Pneumocystis carinii infections. However, we should all be aware of the indications for, contraindications to, and side effects of those medications we do use. On the whole, our individual pharmaceutical armamentarium is relatively small. This will depend on the type of practice we are engaged in. Keeping abreast under this situation is not necessarily overwhelming. Certainly, we owe it to our patients to be knowledgeable; the means are available in scientific journals, in such publications as the Medical Newsletter, and in the AMA Drug Evaluations to say nothing of the standard pharmacology texts. We should not make the drug company representative a scapegoat in this situation. He serves a function in bringing new products to our attention. If there is an unquestioning acceptance of this information, the fault lies with the physician.

We are living in an era of powerful drugs. As the statistics for the incidence of malignancies in immunosuppressed renal transplant patients are released, it is a cause for deep concern. It has recently been estimated that cancer is 80 times more common in patients who receive these drugs than in the general population. We do not fully understand all the actions of such a commonly used chemical as aspirin. Our knowledge of cellular metabolism is in its infancy. We must, in all honesty, admit that we do not know what we may be doing with some of the medications being used today. For this reason, it is doubly important that we have a good understanding of and a valid indication for whatever prescription we issue so that we can follow the Hippocratic injunction: Primum non nocere.

Richard T. Donelan, M.D.
Jacksonville

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What have YOU done to guide FMA?

F. Norman Vickers, M.D.
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Rheumatic Fever Remains a Health Problem

The paper entitled "Rheumatic Fever in Florida" by Drs. Groover and Fulghum in this issue of the Journal deserves the interest and attention of physicians in the state. That more than 1,500 persons with rheumatic heart disease or documented history of rheumatic fever are currently receiving penicillin or sulfadiazene for the prevention of streptococcal infection which might result in irreversible heart damage is sufficient evidence that rheumatic fever remains a health problem. The authors have called attention to the fact that death rates are no longer reliable as a means of estimating the incidence of rheumatic fever and the prevalence of rheumatic heart disease. At the same time they call attention to the continuing need for assessment.

Evaluating the magnitude of any health problem requires the collaboration of the practicing physician. Without a system to provide input from the individual responsible for the primary care of the patient, one can only obtain biased and incomplete information. Inherent in accurate reporting of any disease is the provision of proper diagnostic criteria. The nature of rheumatic fever is such that its protean manifestations overlap several other illnesses. Over diagnosis as well as under diagnosis are frequent and both of these problems are contributed to by the absence of a specific test that allows a definitive diagnosis to be made. It is this situation that prompted Dr. T. Duckett Jones to propose the following:

JONES CRITERIA FOR GUIDANCE IN THE DIAGNOSIS OF RHEUMATIC FEVER

Major Manifestations

Carditis
Polyarthritis
Chorea
Erythema marginatum
Subcutaneous nodules

Minor Manifestations

Clinical
- Fever
- Arthralgia
- Previous rheumatic fever or rheumatic heart disease

Laboratory
- Acute phase reaction
  - Erythrocyte sedimentation rate, C-reactive protein, leukocytosis
- Prolonged PR interval

PLUS

Supporting evidence of preceding streptococcal infection (increased ASO or other streptococcal antibodies; positive throat culture for Group A streptococcus; recent scarlet fever).

The presence of two major criteria, or of one major and two minor criteria, indicates a high probability of the presence of rheumatic fever. Evidence of a preceding streptococcal infection greatly strengthens the possibility of acute rheumatic fever. Its absence should make the diagnosis doubtful except in Sydenham's chorea or long-standing carditis.

It is only by adhering to these criteria that we will be able to avoid excessive misdiagnosis of this disease.

The high incidence of rheumatic heart disease in children and young adults is also pointed out in Drs. Groover's and Fulghum's article. While mortality from acute rheumatic fever has declined, morbidity from heart disease does not show a parallel trend. Rheumatic fever still remains the most common cause of acquired heart disease in children and young adults. Primary prevention of rheumatic fever is achieved by proper therapy of streptococcal pharyngitis (primary prevention). One method was recently demonstrated by two of our colleagues, Drs. Gyland and Lanier (Clinical Peds. 10:566, 1971). An equally important aspect is the use of antibiotics in secondary prophylaxis which entails the administration of antibiotics to all patients known to have had rheumatic fever. Patients who should be placed on secondary prophylaxis include:

1. All patients with an established diagnosis of rheumatic fever, with or without heart disease.
2. Patients with cardiac valve disease, mitral or aortic, for whom a nonrheumatic etiology cannot be established.

Only by preventing recurrent streptococcal infections can we prevent recurrent attacks of rheumatic fever with the associated high risk of further heart damage in these patients. Contrary to some notions, the present recommendation is that prophylaxis should be continued for the lifetime of the patient. It is the cheapest insurance these patients have against the risk of cardiac damage—in fact it is provided by the state free to those who may not be able to afford to buy it.

By recent agreement a Florida Task Force on Rheumatic Fever has been appointed which brings together representatives of FMA, FHA and the Department of Health and Rehabilitative Services. The Task Force will recommend a coordinated state plan for gathering epidemiologic data, identifying "rheumatic" individuals and improving both primary and secondary prevention services to the people of Florida.

SIMON D. DOFF, M.D.
AND ELIA M. AYOUB, M.D.
JACKSONVILLE

We Need Better Bargaining Power

Increasing governmental intervention in the private practice of medicine has stimulated this writer to ponder the overall bargaining position of physicians in our struggle against nationalized medicine. Hopefully, a better understanding of our true position will serve to delineate problems and bring about solutions, thereby enabling us to deal more effectively with the federal government.

After deliberating the matter, I have concluded that we, as physicians, cannot improve our bargaining power without first accepting certain basic facts already discernible to the nation's government. Irrespective of our personal feelings and medical expertise, we are obliged to acknowledge a growing public interest in a nationalized system of health care supported primarily if not totally by tax dollars. Consequently, we must recognize that we are fighting an uphill battle made even more difficult by our having been categorized as a minority group prejudiced because of conflict of interest.

The medical educational process has instilled in us a highly developed sense of individuality and self-reliance, both of which are desirable traits for any physician; however, these same traits have obviated us from presenting a united medical front and probably have been responsible for most of our reactionary attitudes towards any proposed nationalized health plan. We have indeed been fortunate to have medical colleagues who have altruistically contributed time and talent in dealing with governmental attempts to regulate medicine. Nevertheless, it is important to realize that the activity of such involved colleagues has been often significantly curtailed by the demands of medical practice. Finally, if we accept the validity of the foregoing statements, it seems obvious that our current bargaining power offers little competition for the career governmental bureaucrat or professional politician; hence the need for a more productive approach.

It is my opinion that the medical profession has reached a crossroads at which we must decide to either unite as a group or face inevitable total government control. As one who believes in the free enterprise system of private medical practice, I wish to endorse the Florida Physicians Association, Inc., a bargaining organization which is fully supported by the Florida Medical Association, directed by physicians, and devoted to the disposition of governmental and political affairs related to medicine. During its first year the FPA has acquired almost 1,000 members but with more than 9,350 FMA members, we need to do better; therefore, I urge all of you to join this organization and participate in its activities for strength lies in unity. Ideally, one strong organization should replace ineffective political splinter groups and engender the interest of other state medical associations in creating similar organizations or unions.

Daniel B. Nunn, M.D.
Jacksonville

IMPORTANT....

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To Analyze Analysis

Is long term psychotherapy a relic of the past, an expensive almost interminable exercise in self study, or a useful tool for a few difficult psychiatric problems which insurance programs must cover.

No insurance program covering the broad range of man's infirmities can justifiably take an obdurate position and deny a useful treatment when it is conservatively utilized, nor should a company capitulate to the cries of the denied simply because of their vituperation.

As a recent president would say "Let us sit down and reason together." A careful discriminating look at psychiatric illness and available treatment in Florida right at this time reveals several things. We are almost adequately staffed with trained psychiatrists reasonably available in most communities of any size. For example, the Panhandle area which had perhaps ten psychiatrists a decade ago, now has more than 20. Mental health centers for indigent and lower income citizens are generously funded and staffed. The Baker Act was passed to provide community centered care for the low income inpatient, and considerate humane treatment for all. Modern psychopharmaceuticals offer a variable range of chemical therapy to persons suffering depressions as well as schizophrenia. General hospitals have developed inpatient psychiatric units so the insured patient doesn't have to leave his own home area for care. Private hospitals offer a specialized high level of care for those who need and choose such facilities. Psychiatry, as a professional service, may be in a less inchoate stage than is the understanding of the needs of the psychiatric patient by the insurance companies and the general medical community.

If the care of the patient is to be determined entirely by the cheapest treatment available then we should give short cram courses to housewives and the unemployed to do "psychotherapy" and then crowd the state hospitals with all who needed inpatient care and thus save everyone money. If the most expensive form of treatment is to be our mode, then we should schedule all neurotics with the available psychoanalysts, recruit hundreds more of these expensively and expansively trained men, and dream up some way to pay for this perfidious ploy? This comparison is obviously specious. Many neurotics do not need analysis and many would not at all be acceptable as patients.

An insurance program to maintain fiscal soundness must, if possible, have predictable risks and be able to cover these risks without jeopardy to all policy holders. If, however, an inordinate number of insured seek an elective form of treatment that is both protracted and expensive, then rates must go up or insolvency be anticipated. Nor is it fair to compare long term analytic psychotherapy to the neurosurgical or orthopedic care of the traumatized patient, or the often expensive care of the oncological patient, for these measures are of life saving rather than of life enriching or life tolerating intent.

Frank and forthright deliberations by men of good will could lead to resolution of this impasse. Insurance coverage for long term psychotherapy could be made available to those insured members who felt they required this particular form of treatment. If, after the patient has been evaluated by two specialists, one psychoanalyst and one general psychiatrist, it was the conclusion that such treatment was the treatment of choice, it would not seem unreasonable to put a dollar limitation on the total liability of the insurer. $250 a month for the first six months and $150 a month for the next six months would be a modest yet helpful contribution to an attempted restoration to mental health. The company avoids the expensive element of inpatient care. The patient's family should certainly be able to supplement from private funds any deficiency resulting and should feel the company had discharged reasonably its responsibility for an elective therapy.

If at the end of one year, further psychotherapy was contemplated for the insured then it would be understood by the subscriber that he would be "rated up" or his coverage would be terminated. Further, it would be understood that the company would cover only on a 50% participation plan, matching the subscribed dollar for dollar for the required psychotherapy beyond the first year.

Emphasis on short term psychotherapy, group psychotherapy, drug augmentation and the development and utilization of community hospital

inpatient units for short term care has increased the usefulness of psychiatrists in the delivery of mental health services. Longer term care has not been outmoded for it is often an irreplaceable modality, both the in-hospital type and the in-office type of personal psychotherapy. Justifying its need is as important to the insurer as paying for it is to the patient and the provider. Surely it would be fatuous to imply that compromise could not be worked out by intelligent men who do not impugn the honesty of the opponent.

PHILIPS B. PHILLIPS, M.D.
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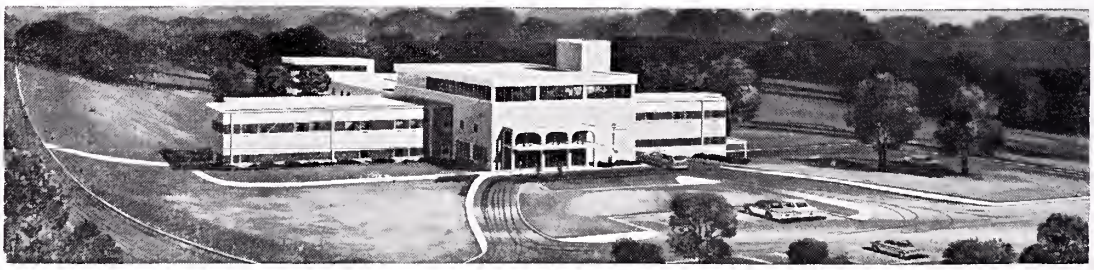

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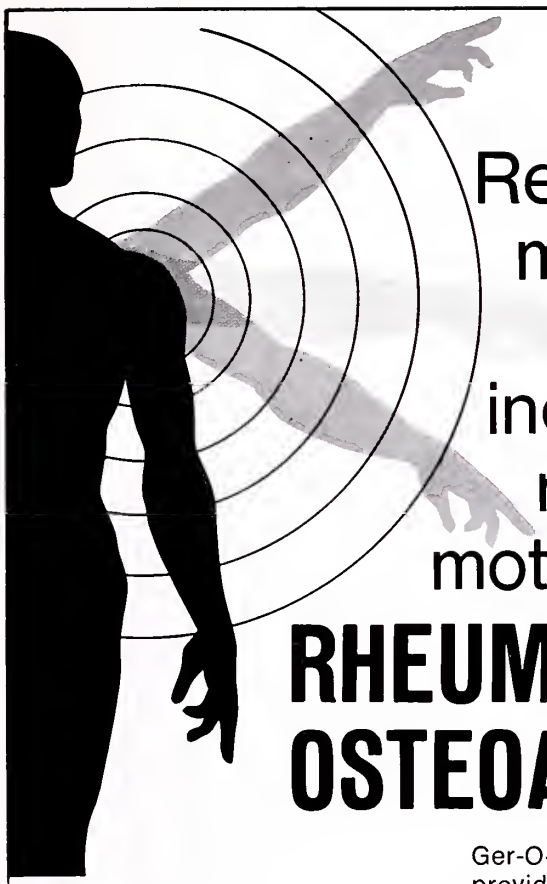

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1. Gordon, E. E. and Haas, A., Indust. Med. & Surg. 28:217, May, 1959.

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Our Retiring President

JOSEPH C. VON THRON, M.D.

Joe Von Thron

Several years ago at an annual FLAMPAC luncheon, a former U. S. presidential contender sounded like a country bumpkin after being introduced by a Florida physician, whose smooth delivery and eloquent introduction convinced everyone there that he had a great future. It wasn't long after that until his county society announced their campaign to nominate him for president-elect of FMA. The following year, he was elevated to this position by the House of Delegates without opposition. And so, last May, at the close of the 99th annual meeting, on receiving the gavel from the outgoing president, Joe Von Thron adjourned the House of Delegates and soon after, as his second official act, opened a meeting of his Board of Governors, the first of many. The most controversial action of that House of Delegates meeting had been approval of a state Professional Standard Review Organization and the Board was to devise articles of incorporation. That same month, Joe went to Washington with Burns Dobbins, President of the Florida PSRO, Inc., for an AMA meeting on this subject. In June, at the AMA convention in New York, he was inspired by the attitude and activities of Francis Holland and our delegates and he was up with them every morning at 7 a.m. conferences and then through long sessions of the house for support of FMA grass roots philosophy. In his President's Page* in the Journal, he publicized the dedication, the sacrifice of time, the sincerity and devotion of those physicians who represented Florida. As a six year former member of the Board of Directors of Blue Shield, he continued to support it and encouraged the doctors of Florida to do so. He pointed out that Blue Shield was an answer to a national health insurance program sponsored by Senator Claude Pepper of Miami, who had done us a favor by raising the Florida physician from his apathy, forcing him to become concerned about how patients pay their bills. In October, he flew to Mexico with the Board of Governors, where he presided over a three day meeting at the Pierre Marquis Hotel in Acapulco. The 1973 FMA Annual Meeting was evaluated and a program designed for the Centennial Meeting in 1974. Committee appointments were approved. Peer review for Medicaid, the FMA Professional Liability Insurance Program, and a report from the President of the Woman's Auxiliary were items on the agenda. The Florida Physicians Association, Inc., osteopaths, medical student membership and legislative activities that could affect doctors, were among subjects debated for approval. Bob Zellner, suffering from Montezuma's revenge, was able to throw off the disease long enough to report at length on Blue Shield and received approval plus an expression of continued support from the Board. Gerry Schiebler, appointed to his first year as Chairman of the Council on Scientific Activities, reported on plans for continued education of physicians and a revised Committee on Medical Education to maintain liaison with the Board of Regents of the State University System. Joe and the Board listened to Harold Parham describe the orderly transfer of FMA Professional Liability Insurance Program from Marsh and McLennan, Inc. to Harlan-Med.

Traveling again to Washington, he told HEW Secretary Weinberger that the government was meddling with the finest medical care delivery system the world has ever seen and that PSRO was a mistake. To counteract this mistake, he suggested to FMA members that they find a way to get the facts to the voters, for what professional man talks to more voters each day than a doctor? He told physicians to tell their patients that there is no medical crisis and no need for PSRO or HMO. In December, he attended the AMA meeting in Anaheim with our delegates. Returning home again to take up his practice, he found time to spend Christmas with his family. Inundated with presents from grateful patients and Christmas cards with special messages from friends, he considered well worthwhile the many years he had spent in organized medicine and the longer years as a family physician. Continually on his mind was PSRO, which was repeatedly examined with the Executive Committee of the Board of Governors as to how to advise Florida physicians what should be done. Joe called PSRO "unnecessary, undesirable, ill-conceived and a poorly formulated program." Approving-action by the 1973 House of Delegates had been based on the assumption that review would be by Florida doctors operating in the coordinated framework of our

*Two of them were reprinted in American Medical News.

state organization. Yet HEW refused to approve the FMA corporation and Joe, believing that the regulations were "arbitrary, inflexible and totally unacceptable," thought that we should reconsider our position. He pondered calling a special meeting of the House of Delegates. After prolonged debates with the Executive Committee, he reached the decision that we should go along with the AMA policy of working in the PSRO framework but at the same time, encouraging the legislators in Washington to repeal the law. Concerned about membership apathy, Joe spoke before nine county societies whose rolls contained more than half the physicians in Florida.

In January, he worked during a long, long weekend with Thad Moseley at the FMA Leadership Conference in Orlando where 176 persons, representing 34 of FMA's county medical societies, attended. At the March meeting of the Board of Governors, he talked a lot but listened more, keeping the agenda moving progressively as enthusiastic plans were made for the 100th anniversary of the Association. At this meeting, Joe announced the massive reorganization of the unwieldy FMA councils and committees, details of which were later to be presented to the House of Delegates for By-Law changes.

Because of declining attendance at the annual meetings, Joe worked hard to put on a program this year with something for everyone. Beginning with the jampacked scientific sessions Thursday is a section on Infectious Diseases and Antibiotics followed that evening by the Reproductive Biology Research team of Masters and Johnson. The next day outstanding speakers will talk on Emergency Medicine, Nephrology, Family Practice, Ischemic Heart Disease to be followed that night by the President's reception and a Centennial banquet at which time Sammy Kaye will entertain.

In May, during the final days of his year in office, he will preside with his usual eloquence, treating subjects of a humble nature with delicacy, lofty things impressively and moderate things temperately. Yet, it's not what he says but who he is that gives weight to his eloquence, for his steadfastness, his sense of obligation toward his colleagues and his God, combined with his enthusiasm toward what is right, are qualities that make him stand out. Oliver Wendell Holmes once categorized men into: "One-story intellects, two-story intellects and three-story intellects with skylights. All fact-collectors, who have no aim beyond their facts, are one-story men. Two-story men compare, reason, generalize, using the labors of fact-collectors as well as their own. Three-story men idealize, imagine, predict; their best illumination comes from above, through the skylight." Joe was selected to lead the Florida Medical Association because his was a three-story intellect. Florida physicians will long remember, always admire and forever look up to him because of this.

Joe, your reward will be not what you have gotten for your toil but what you have become because of it.

C. M. C.

The reward of a thing well done is to have done it.

—Ralph Waldo Emerson

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Medical News

Nixon Gets Aging Post

Mr. Eugene L. Nixon, Associate Executive Director (Programs) of the Florida Medical Association, was installed as President of the Florida Council on Aging on March 24. He succeeds Mrs. Rowena E. Rogers, R.N., of Clermont.

The Council consists of both organizational and individual members. It is active in problems related to gerontology and geriatrics.

MH Director Search Begins

The Florida Department of Health and Rehabilitative Services has formed a search committee to look for a successor to State Mental Health Director W. D. Rogers, who retires in July.

Responsibilities include direction of the state's mental health program, including state hospitals, mental health institute, Bureau of Alcoholic Rehabilitation and support of 44 community mental health centers and clinics.

Applicants should be a graduate of an accredited medical school and be licensed to practice in at least one state. They should also have training and experience in the field of psychiatry to meet the requirements for examination by the American Board of Psychiatry and Neurology.

Curriculum vitae should be sent to the chairman of the Search Committee, William C. Ruffin Jr., M.D., Department of Psychiatry, University of Florida College of Medicine, Gainesville 32610.

New Cancer Group Formed

A new medical organization called the Southeastern Cancer Research Association has been formed with Julius Schultz, M.D., President of the Papanicolaou Cancer Institute of Miami, as President.

The group held its first organizational and scientific meeting in Atlanta last October. The purpose of the organization is to provide a forum for the regional exchange of basic and clinical cancer research efforts.

Information may be obtained from the Secretary, Dr. Wayne E. Criss, Department of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville 32610.

Family Practice Review Program

The University of Florida College of Medicine is sponsoring a Family Practice Review Program for practicing physicians, June 3-8 in Gainesville.

The American Academy of Family Physicians has been asked to approve the course for 44 hours of credit. Registration will be limited to 100 physicians and the fee will be $150.

Information may be obtained from: Dr. Bernice S. Scott, Director of Continuing Education, University of Florida, 807 Seagle Building, Gainesville, Fla. 32610.

New BME Officers

Carl C. Mendoza, M.D., of Jacksonville, has been elected President of the Florida State Board of Medical Examiners, succeeding Vernon B. Astler, M.D., Boynton Beach.

Other new officers of the BME are: John J. Cheledon, M.D., Daytona Beach, Vice President; and Victor Martinez, M.D., Tampa, Secretary.

20th Annual Ob.-Gyn. Seminar

The 20th Annual Southern Ob.-Gyn. Seminar will be held at the Grove Park Inn at Asheville, N. C., July 21-26.

Program participants will include faculty from the medical schools of Duke, Bowman Gray, North Carolina and the Medical College of Virginia.

Information may be obtained from George T. Schneider, M.D., 1514 Jefferson Highway, New Orleans, Louisiana 70121.

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Letters

Open Letters to Secretary Weinberger

Dear Mr. Weinberger:

I am writing to express my objection to the proposed hospital pre-admission regulations for Medicare and Medicaid patients.

While it is not only understandable but desirable to attempt to effect economy in the provision of health care to all segments of the population, the above proposal would produce so many undesirable consequences that its positive effects would be negated.

The adding of another bureaucratic lawyer to the existing (Medicare and Medicaid) and proposed (PSRO) regulatory agencies and mechanisms will inevitably result in increasing costs. The physician time demanded to operate such a program, whether on a full-time, part-time, salaried or voluntary basis, will decrease the available physician time for patient care.

I have recently analyzed the time I now spend as a physician in activities not directly involved in patient care. I found that rounds, conferences, lectures, staff meetings, committee meetings (including utilization review, record and quality review) clinics, service tours, etc., consumed over 44 eight-hour days last year. State, National and Specialty Society meetings occupied another 14 days. The above does not include the hospital or office records, forms, correspondence, etc., the completion of which takes another two or three hours weekly.

I assure you that such an expenditure of time by physicians is by no means uncommon; many spend much more time than this in such activities. Indeed, I spend less time now than formerly when I was a member of the Board of Governors of the Florida Medical Association, the Board of Governors of the American College of Surgeons, or President of the Dade County Medical Association.

With such an enormous block of time carved out of my life by these necessary and essentially desirable activities (for the most part) I have come to resent and resist any further encroachment on my time. When I am approached about the completion of another form which "only takes a few moments," I remind the requester that spending an extra minute a day on a regular basis five days a week means four hours and ten minutes a year (50 weeks). In the course of thirty years of practice this means that three weeks and five hours will have been taken from me, and if I give up five minutes daily, fifteen weeks and three days—nearly four months—will have gone down the drain. I feel, therefore, that any new activity to be undertaken in this area must have an unquestionable reason for its adoption. I question the personal "cost-effectiveness" ratio in the proposed hospital pre-admission regulations.

Those of us who will cooperate with the program adopted, and indeed will be called on to administer or monitor the program, will find ourselves at a great disadvantage and severely penalized by inequities which will occur by encouraging false or pseudo-emergency admissions by those who always find a way to "beat the system."

Another objection to adopting pre-admission certification is that we are, in effect, saying that hospital costs cannot be controlled, therefore we must keep patients out of hospitals. Since hospitals have been put on a virtual cost-plus basis, enormous inefficiencies have resulted with no effort to control costs. Lawyers of bureaucratic controls have been added in the larger hospitals with the main idea of keeping a more accurate breakdown of chargeable items for the so-called cost accounting. The hospital supply people have joined in the chase for tremendous profits by promoting disposal equipment and supplies. Since the cost is passed on, hospitals have only too gladly bought the idea that disposables are cheaper and safer, since this eliminates the need for training personnel how to properly care for equipment (not a very complicated problem at worst!). As a consequence we use up, needlessly, enormous quantities of our resources and accumulate mountains of material which must be disposed of, thus contributing to pollution.

And then the big problem of the patient himself who must be informed that medical care cannot be provided on an open-ended basis any more than food, shelter or clothing can be so provided. Our medical care resources (particularly personal physician care and hospitalization) must be husbanded just as carefully as our other resources in order to insure against depletion and/or inequitable distribution. One of the best ways to do this is to have the patient participate in the payment for each service rendered, within his ability to do so. Although I have not had a chance to study the President's Health Bill, a casual analysis of the bill reveals that this feature is incorporated in it, at least to some extent, and I applaud this recommendation.

Finally, something must be done about the cost of liability awards and the threat of liability awards to patients resulting from suits against doctors and hospitals. The public must understand that nobody gets something for nothing; that the cost of the escalating professional liability premiums must be paid for by someone and that at least a portion of that is passed on to the patient. Furthermore, the cost of unnecessary tests, hospitalization and/or treatments is the result of individuals' or institutions' anxiety to render themselves judgment-proof.

Mr. Secretary, in giving you the reasons for opposing the hospital pre-admission regulations, I hope I have been constructive in pointing out some areas where I believe much effort is needed in the health care field. For those of us who had the privilege of serving patients, both private and service, as their personal physician over two or three decades or more, the increase in the quality as well as the quantity of care which we have been able to provide never ceases to amaze, as new knowledge, materials and techniques constantly unfold. On the other hand, I share the impatience of those who see so much yet to be done and are anxious to try new ideas and get on with new approaches. I disagree with those who, lacking perspective, would scrap the existing structure which has served and is serving so well, and which can be extended or built upon to further improve medical care.

I hope you will call upon me as an individual, and the medical profession as a group, to support genuine programs which will result in the betterment of medical care specifically, and health care generally.

Richard M. Fleming, M.D., F.A.C.S.
Miami Beach

Dear Mr. Weinberger:

I have just read the proposed new regulation regarding pre-admission screening, and again I am seriously disturbed at the apparent lack of insight among the decision-making authorities in our government.

This method of solving problems will surely produce a large number of additional problems. If nothing else, it would require a lot more of a physician's time—time that is seriously needed by sick people.

This approach was begun in Germany in the time of Bismarck and, since he was the "Iron Chancellor," it was not possible to throw it out when it proved to be unworkable. The practical-minded German doctors who were subjected to it, simply made practical adjustments and have allowed it to continue to the present day. It prevents no abuses, it requires certain standardized inventiveness, and it satisfies bureaucrats.

If you are not familiar with what I am talking about, ask a few of the German doctors who have recently moved to the United States to practice.

Please don't let this type of thing be crowded into our already difficult schedule.

Willard E. Manry Jr., M.D.
Lake Wales, Florida

To the Editor: As a public service project, the Marco Island Kiwanis Club is attempting to determine if sting ray attacks are as serious throughout the State of Florida as they are here at Marco Island. We have contacted 16 hospitals on both coasts and in the Keys for data. The results are that the east coast is reported to be almost free of sting ray injuries while the Gulf coast south of Tampa Bay has what appears to be a serious problem.We need better data if we are to approach federal and state agencies and private foundation groups for financial support of a research program aimed at reducing the occurrence of sting ray injuries.

I would appreciate it if you would inform me of any suggestions you might have for obtaining more reliable data, particularly through the use of the Journal.

George P. Spinner
Kiwanis Club of Marco Island
Marco Island, Florida 33937

Editor's note: If you have any information on sting ray injuries or know anyone who has, please contact Mr. Spinner.

An Open Letter to the Editor of The Miami Herald

Dear Sir:

This is in response to your editorial in The Miami Herald of February 4, 1974 entitled "State Boards Need Doctoring." In this editorial you made several sweeping statements, assumptions and conclusions which I feel erroneous and not based on facts.

You stated that at least a hundred Cuban doctors are now working illegally in the "clinicas." This is not necessarily so. These unlicensed Cuban M.D.s are not working illegally if they are acting as assistants under the responsible supervision of licensed M.D.s as they are supposed to be. This Board, in November 1973, advised all licensed M.D.s in the "clinicas" of their legal responsibilities in employing and supervising unlicensed personnel and not allowing them to engage in the practice of medicine in violation of the law.

You stated that the Board "routinely" rejected Senator Pettigrew's recommendation to the Board that temporary Physician's Assistant certificates be issued to the unlicensed Cuban doctors. The Board did not "routinely" reject this recommendation but all members thoroughly discussed it with Senator Pettigrew. In declining to carry out the recommendation, the Board acted in the public's interest primarily and rightly felt that these temporary certificates could not be limited to Cubans only but would have to be issued to any unlicensed M.D. from any state of the U.S. or any other country in the world. This did not in any way reflect, as you stated, a lack of concern for the quality of medical care Floridians receive.

You stated that the Board of Medical Examiners, like other state boards controlling various professions, did not see itself as a public-oriented body but rather as a protective organization dedicated to taking care of members already in the club. This is as pompous and arrogantly presumptuous a statement from an editor's lofty sanctum sanctorum as I have read in a long time. Our Board members repeatedly state during every meeting or hearing that their first and most important function is protection of the public in health matters or in individual doctors who come before it. Furthermore, during the last ten years the number of doctors licensed to practice in Florida and actually in-state has doubled. Since 1969 Florida has been among the first three to five states in numbers of M.D.s licensed yearly. The medical profession, with 11,000 M.D.s in-state, has disciplined more of its licensees in the past five years than the legal profession with 15,000 lawyers. The Board supported all legislation which has since 1969 allowed more M.D.s to qualify for Florida licensure and we now have endorsement with 48 of the other 49 states and with the graduates of all medical schools in the U.S. who use the National Board of Medical Examinations (95% of them use it). Taking care of the members already in the club, indeed.

You stated that an attempt to legislate a lay member onto each occupational and professional board went down to defeat under a barrage of lobbying and that the dentists, doctors, real estate brokers and accountants ganged up and pressured an 11-5 House Committee vote in their favor, rather than the public's. This issue was discussed calmly, pro and con, and the committee voted in the same manner. These elected public representatives are intelligent men; you insult and underestimate them in your erroneous assumption . . . Since Castro took over Cuba, approximately 3,000 M.D.s left that country. Of this number at least 1,200 (40%) of the total have been licensed in Florida. During our last three examinations 50% of the total applicants were foreign medical graduates and half of these (25% of the total) were Cubans. Of the 204 unlicensed Cuban M.D.s in the Dade County area in 1972, 103 of these were 70 years of age or older and 101 were over 60. Some of these were successful in obtaining licensure during the last year leaving a more or less irreducible minimum who cannot pass because of age, language and just not keeping up with the progress in medicine. The Cuban doctors have the same chance with the Medical Board as do any other doctors who possess the required qualification. Our Board does not believe in two levels of medical care—only one with no favors, exceptions or discrimination. We demand more and we get it. In holding the qualification and quality line high the end justifies the means as far as M.D. providers of health care are concerned and that is our bag.

George S. Palmer, M.D., Executive Director
Florida Board of Medical Examiners
Tallahassee

Editor's Note: The above letter to The Miami Herald, published with the permission of the writer for the edification of our readers, needs no explanation.

Editor's Note: This is a second communication from the anonymous physician from Mars; the first appearing in the April issue. He has promised to see us at the Centennial banquet. If he's a man of his word, and if he's anything like his portrait, it just might be worth your time to look in on that affair. A lot of your friends will be there having a good time.

Dear Earthdocs:

Thank you for letting me communicate with you again. I eagerly anticipate seeing all of you at the Centennial Celebration of Flat Land Medical Association. Perhaps I can learn some things about earthdocs which will be of interest to my Martiandoc colleagues at home.

Your earth planet civilization is a young one, by Martian standards. Several millennia ago, we settled the postgraduate education problem. I understand that this physician postgraduate education controversy has raised its head in many professional medical associations. I understand further that occasionally it has been raised in State legislatures as well. Fortunately for the state of Flat Land, required hours of postgraduate education has been voluntary on the part of the Medical Association rather than mandatory through the State legislature. Let's hope it stays that way.

As I was saying, we Martiandocs have solved that postgraduate education problem in our hazy, distant past. Like the Flat Land Medical Association, postgraduate education used to be voluntary. Now the state of knowledge has advanced so that once a year the Martiandoc is called in for inspection and repairs. He has a special socket in his head which is compatible with our best computer. This computer information is re-programmed for him in a matter of about 15 minutes. Consequently, you can see that this is a great increase in efficiency. It also reduces the incidence of headaches and hemorrhoids in our Martiandocs, since they do not have to sit through boring, tedious lectures. However, the incidence of backaches is about the same since Martiandoc wives frequently assign yard duties to the physician-husband since he has no postgraduate medical education excuse as in former centuries.

Occasionally, a Martiandoc develops tapes which will no longer accept the new computer information. In that case, he is retired to live out his remaining years in peace and tranquility, no longer treating patients. Frequently, he will be honored with the post of state or national medical elective office, state voluntary insurance program, hospital administrator, or trustee. If senility becomes severe or psychosis becomes severe, occasionally he runs for political office at the state or national level. I will be interested in learning what you do with your physicians who no longer qualify in postgraduate education.

See you at the Centennial!

Sincerely,
Martiandoc

To the Editor: In the past twenty years, our laboratories have examined more than 20,000 specimens of rodents (and rabbits)—ground squirrels, rats, mice, hamsters, gerbils, guinea pigs, chipmunks and gophers—and found only one case of rabies—a flying squirrel, in 1961. This leads to the conclusion that naturally occurring rabies is rare among these animals.

Since 1969, the U. S. Public Health Service has advised that "bites of rabbits, squirrels, chipmunks, rats, mice, guinea pigs, gophers and hamsters seldom, if ever, call for rabies prophylaxis." This recommendation is based upon the very low rates of infection found in wild rodents. It is further supported by the fact that there has never been a reported case of human rabies in the United States attributed to rodent exposure.

Based upon the rarity of naturally-occurring rabies in rodents and the absence of reported human cases resulting from bites, the Division of Health recommends that rabies immunization be instituted only for high-risk bites. The patient would be immunized in the event extraordinary considerations suggest the possibility of greater than usual risk. These considerations include any kind of bizarre behavior such as an unprovoked bite or obvious illness. Bites frequently occur with feeding and/or handling and do not constitute a basis of suspicion. Caged pets are of little or no risk to the individual bitten.

The Division of Health recommends that rabies examination of rodent specimens be requested only in situations which suggest an increased risk in rabies transmission. Often circumstances surrounding the emergency provide the information needed to allay the patient's anxiety and prevent further investigation or treatment. On the other hand, the facts may occasionally warrant laboratory assistance.

Wilson T. Sowder, M.D., Director
Division of Health
Jacksonville

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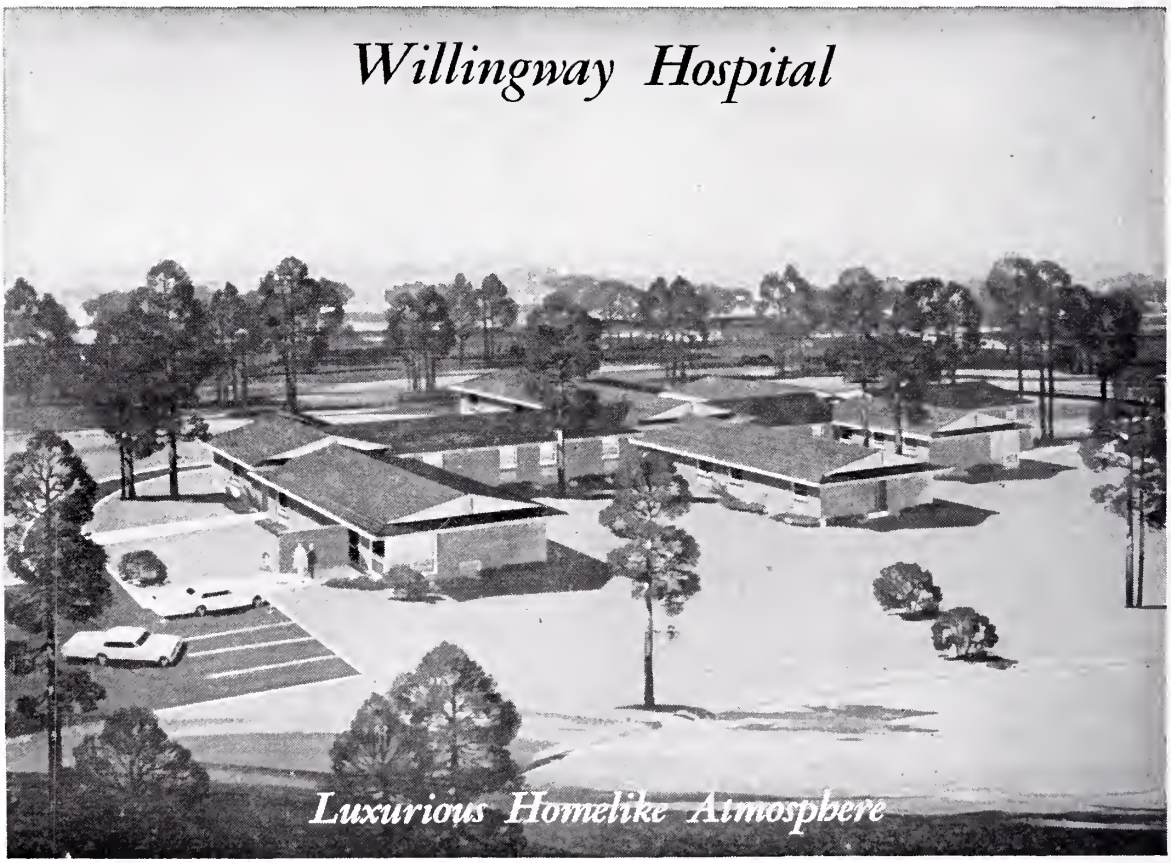

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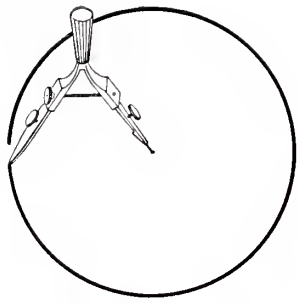

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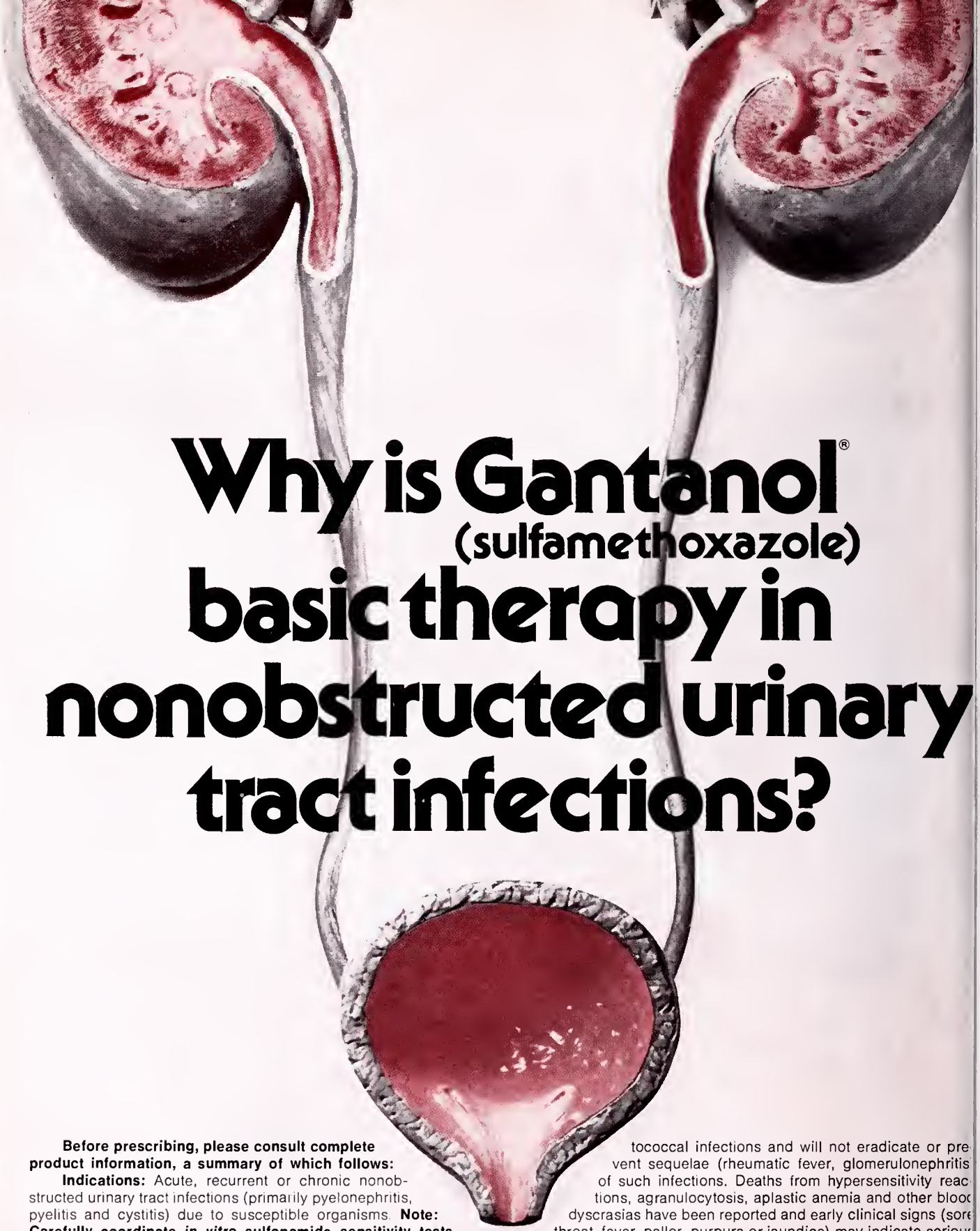

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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

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pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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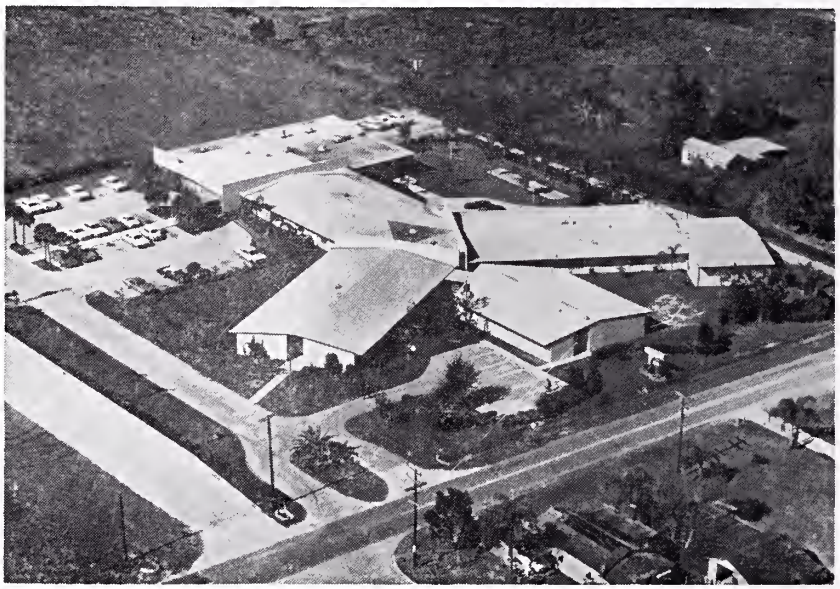

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CENTRAL FLORIDA AREA: Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

FAMILY PRACTITIONERS WANTED: One of the fastest growing communities in the U.S., Seminole, Florida, urgently needs family practitioners. Only minutes from Tampa, St. Petersburg, Clearwater and beach areas. Newly opened 100-bed acute general hospital. Offices provided on hospital property with rent free provisions. Will assist in referrals of patients. Write or phone Carlton K. Flores, Administrator, Lake-Seminole Hospital, 9675 Seminole Boulevard, Seminole, Florida, 33542. Phone (813) 393-4646.

GENERAL PRACTICE: Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

WANTED: LOCUM TENENS for three weeks in June. Leesburg, Florida. General practice, no OB. Florida license. Salary $150 day. Partnership also available. Call Dr. George E. Engelhard at (904) 787-1600 or 787-5315.

FORT LAUDERDALE AREA, third associate for family medical group, A.A.F.P., position available in approximately 6 months. Send curriculum vitae to M. Sluchak, M.D., 6991 W. Broward Blvd., Plantation, Florida 33314.

GENERAL PRACTITIONER WANTED in central Florida. Three areas available. Population ranges from 5,000 to 50,000. Good hospital facilities available. Excellent opportunity professionally. Surgery and OB only if desired. Well established medical practice. Salary or percentage. Good fringe benefits, insurance, medical reimbursement and liberal pension plans. Send resume to: Lawrence C. Taylor, M.D., P.A., 1145 Lakeland Hills Boulevard, Lakeland, Florida. Phone: (813) 682-4913.

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INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

PATHOLOGISTS—550 bed Florida hospital. Hospital is seeking two pathologists who are board certified in clinical and anatomical pathology to head up fully automated and efficient lab. Florida licensure or passed FLEX exam within last 8 years is required. Desire physicians willing to work for outstanding salary but contract arrangements are possible. Send resume. Write C-635, P.O. Box 2411, Jacksonville, Florida 32203.

ANESTHESIOLOGISTS: 500 bed Florida hospital. Large hospital in Fort Myers, Florida is in need of more anesthesiologists to join its staff. All anesthesia is given by M.D.'s and present anesthesia group of 5 is encouraging board certified, Florida licensure (or pass FLEX within 8 years) M.D.'s to come to this area. Excellent opportunity for a satisfying medical practice and a chance to enjoy life playing golf, tennis, boating, or fishing in the warm tropical sun. Direct inquiries to J. Barry Johnson, Executive Vice President, Lee Memorial Hospital, P.O. Drawer 2218, Fort Myers, Florida 33902.

GENERAL SURGEON: Expanding surgical group needs surgeon in southeast Florida. Board certified or eligible, Florida license. Excellent growth potential in the group and community. Send curriculum vitae and references to C-628, P.O. Box 2411, Jacksonville, Florida 32203.

MIAMI, FLORIDA AREA. Seven man multispecialty, fee-for-service group is seeking an internist to join the group. Generous first year profit guarantee. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

INTERNIST, to become an associate with internist in Miami, Florida. Guaranteed salary, plus percentage, working towards full partnership at later date. Write C-635, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-619, P. O. Box 2411, Jacksonville, Florida 32203.

OTOLARYNGOLOGIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-620. P. O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIC SURGEON: Attractive opportunity in North Central Florida. Community has well-equipped, new 128-bed hospital and does not currently have an orthopedic physician. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

WANTED-THORACIC SURGEON: Energetic board qualified, or certified, with Class A background, United States gradute, and military obligation completed, to join busy all surgical group. Southeast coast of Florida. Write C-629, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNAL MEDICINE: To take over private practice for free starting July 1, 1974 in Fort Lauderdale area. Excellent hospitals. For additional information phone (305) 792-0400.

Miscellaneous

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. Hematologist, Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccousukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

FAMILY PRACTITIONER OR INTERNIST WANTED to join newly formed clinic in newly developed ITT community. Full or part time. Excellent opportunity for retired physician to supplement income. Financial arrangement flexible. Write or call: Jack Dunn, M.D., 4 Carol Court, Palm Coast, Flagler Beach, Florida 32036. Phone (904) 445-3868.

WANTED: E. R. Physician for day shift, ten hours per day, five days a week. Must have Florida license and provide references. Write or call, Administrator Highlands General Hospital, P.O. Drawer 2066, Sebring, Florida 33870. Phone: (813) 385-6101.

DEVELOPING MULTISPECIALTY GROUP oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Internists, Cardiologists, Pediatricians, General Surgeons and General Practitioners. Contact: H. D. Williams, M.D., President, Williams, Abbey & Sells, M.D.'s, P.A., Richey Medical Center, P.O. Box 1000, New Port Richey, Florida 33552. (813) 842-8494.

EMERGENCY ROOM PHYSICIAN—FLORIDA CAPITAL CITY: to join other physicians in full E.R. coverage of 511-bed general hospital. 42 hour week, Florida license required. Beautiful location in university town, abundant fishing, water sports and hunting. Excellent schools, choice home sites. Minimum income of $40,000 with opportunity to increase. Contact Dr. George H. Evans, Chairman, Emergency Room Committee, Tallahassee Memorial Hospital.

WANTED: PHYSICIAN to join several other physicians in emergency room practice in central Florida community hospital, 150 beds. Approximately 40 hour week. Benefits include four weeks vacation and two weeks for medical meetings. Starting salary $38,000 yearly. Must be graduate of U.S. medical school and some previous practice desirable. Florida license necessary. Contact: Thomas E. Langley, M.D., Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-4161.

KINGS POINT, a rapidly growing senior adult condominium community, urgently requires physicians (including specialists). More than 3,000 residents without onsite medical care. Opportunity for immediate flourishing practice. Hospital privileges available. Desirable southern Palm Beach County, Florida. Apply to Office of the President, Kings Point, 7000 Atlantic Avenue, Delray Beach, Florida 33444.

INTERNIST OR GENERALIST WANTED to join two doctor practice in internal medicine and geriatrics. Beach area Fort Lauderdale. Florida license. Salary first six months, then partnership. Excellent hospital privileges. A. Joseph Pitone, M.D. and Louis L. Amato, M.D., 2600 N.E. 9th St., Fort Lauderdale, Florida 33304. Phone: (305) 564-7597.

FAST GROWING OCALA IN NEED OF ALL TYPES OF PHYSICIANS! Two brand new hospitals plus a 6½ million dollar expansion program under way at Monroe Memorial Hospital. Several medical suites, 1,000 sq. ft. to 5,000 sq. ft. Immediate occupancy, with all utilities, janitor service and unlimited parking, in an established centrally located medical complex. Call collect E. E. Conrad (904) 236-2343, P.O. Box 216, Silver Springs, Florida 32688.

WANTED CENTRAL FLORIDA: GP, Internist and Pediatrician to join four-man group well established in a community located in the heart of citrus and cattle country. New 50-bed hospital directly across from office. Excellent educational and recreation facilities. Please send curriculum vitae to Barbara C. Carlton, M.D., P.O. Box 1270, Wauchula, Florida 33873.

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UROLOGIST: Completing military obligation September 1974. University trained. Florida license. National board certification. Desires association leading to partnership or group practice anywhere in Florida. Contact Joseph G. Thro, M.D., Dept. of Urology, David Grant Medical Center, Travis Air Force Base, California 94535.

35 YEAR OLD GENERAL SURGEON WITH SPECIAL INTEREST in vascular and thoracic work interested in association or group practice. Available July 1, 1974. Phone: (303) 371-4490 or write 12391 Randolph Place, Denver, Colorado 80239.

OTOLARYNGOLOGIST, age 37, board certified, trained and licensed in Florida. Desires association leading to partnership, but would also consider group practice, or solo practice in community in need of an ENT specialist. Write C-632, P.O. Box 2411, Jacksonville, Florida 32203.

RADIOLOGIST—Florida license. Would like small hospital department. Also interested in purchasing radiology practice. Board certified. Write C-636, P.O. Box 2411, Jacksonville, Florida 32203.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P. O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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to help reduce clinically significant anxiety and thereby help improve patient receptivity

Librium® up to 100 mg daily in severe anxiety (chlordiazepoxide HCl)

Please see following page.

Symptom of excessive anxiety:

The patient may have difficulty in accepting medical counsel.

Clinical experience has shown that some unduly anxious patients may tend to deny or minimize their illness and therefore resist seeking or following medical advice. Through its antianxiety action, adjunctive Librium (chlordiazepoxide HCl) can often calm the emotionally tense patient, thereby encouraging physician-patient rapport and, on occasion, making it easier for the patient to accept medical counsel.

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(chlordiazepoxide HCl)

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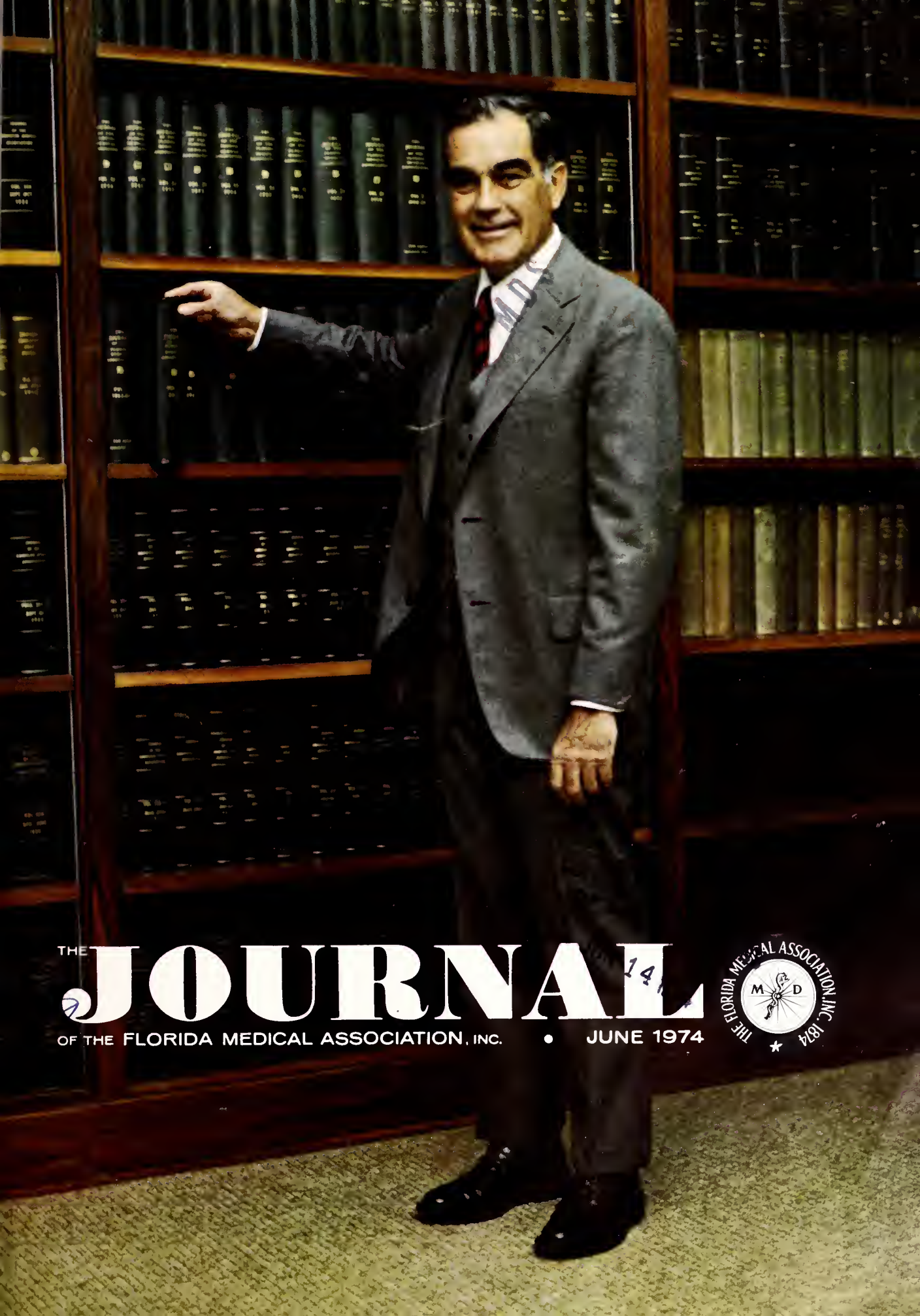

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JUNE 1974

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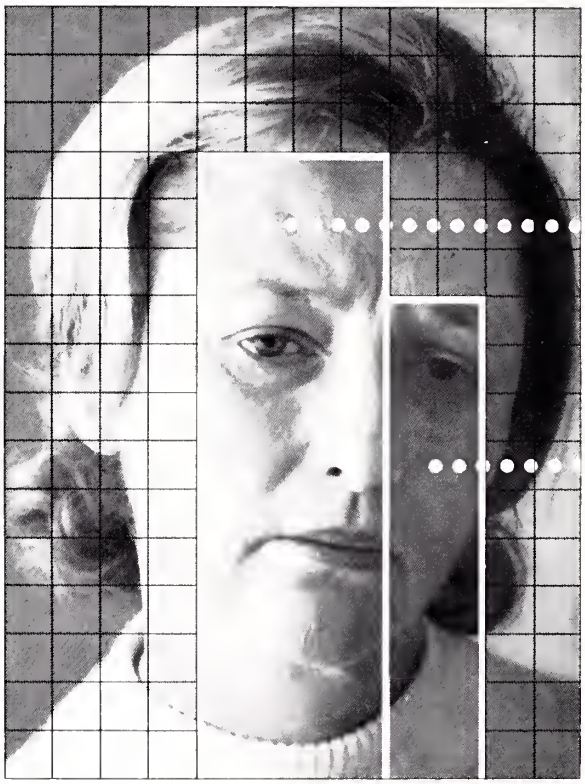


Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

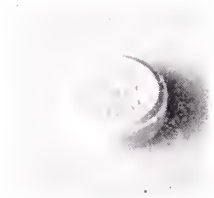
According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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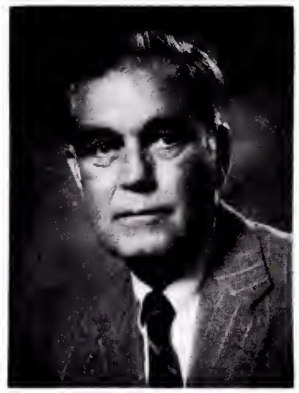
President's Page



Get Involved!

Each President assumes office with enthusiastic plans for the year ahead; I am no exception. Of primary importance for 1974-1975 is getting members of the Florida Medical Association involved in its activities.

I recognize the pressure upon you as a physician—from government, from insurance carriers, from the public, and even from patients—and I do not want to add additional problems. Instead, I want you to become involved because you can contribute, and because all of us stand to gain from your contribution.

To bring your opinions to the Association's official attention, the revised council and committee structure authorizes a committee of county medical society presidents. They will be responsible to me as President and to the Board of Governors, who as representatives of the entire membership are ultimately responsible to you.

I have appointed another group of medical leaders, representing all areas of the state, whose task will be to study the Association's activities and recommend changes. They have been requested to study the alignment of the medical districts, the Board of Governors representation, the place of the FMA Journal Editor in our official family, the term of office and method of selecting alternate delegates to the American Medical Association, a structured versus an unstructured format for some FMA meetings, a more direct involvement of county medical society executives in Association deliberations, the FMA-Blue Shield relationship, Blue Shield versus a commercial insurance carrier as Medicare intermediary for Florida, and other matters they believe important.

I hope you will suggest areas for the committee members to consider.

Throughout this year as your President, I will present the official decisions of the House of Delegates at all times. I will listen for your constructive suggestions. I will work for you to these ends. I ask that you become involved—become an ACTIVE member of the Florida Medical Association.

Thad Moseley

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estrogens Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estrogen complex in the proportions found in its natural source. And for more than thirty years PREMARIN has enjoyed an unparalleled record of clinical efficacy and acceptance.

PREMARIN. The only estrogen preparation available that contains natural estrogens exclusively and also meets all U.S.P. specifications for conjugated estrogens. Assurance of quality for you and your patients.

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BRIEF SUMMARY
(For full prescribing information, see package circular.)
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(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thromhosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should he performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should he examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no ahsolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should he administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arhitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

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Chemosurgery Center at Miami

The Mohs Chemosurgery Center has been established at the University of Miami School of Medicine for the treatment of recurring skin cancer.

The facility was named for Frederic E. Mohs, M.D., of the University of Wisconsin School of Medicine, who developed the technique. The Center will be under the director of Henry W. Menn, M.D., Assistant Professor of Dermatology.

Cancer Professorship

Rodney R. Million, M.D., Professor of Radiology and Chief of Radiation Therapy at the University of Florida College of Medicine, has been awarded an American Cancer Society Ed C. Wright Memorial Professorship in Clinical Oncology.

Mr. Charles Lance, President of the Florida Division, American Cancer Society, said the professorship involves $90,000 for a five-year period. Dr. Million was selected on the basis of his abilities as a cancer educator and as a clinician in the management of cancer.

Medical Documents Stolen

A New York anesthesiologist has reported that several documents belonging to him, including a Florida license, have been stolen.

Simon Halevy, M.D., informed the Florida Board of Medical Examiners, that the following documents are missing: a 1946 baccalaureate diploma awarded in Bucharest; medical diploma (2 parts), Bucharest, 1955; American Board of Anesthesiology Diploma, 1968; 1973-74 State of Florida Board of Medical Examiners Registration Certificate; and a 1973-74 State of New York Education Department Registration Certificate.

Any physician who comes into contact with an individual who identifies himself as Dr. Halevy or who presents any of these credentials should report the incident to the Florida Board of Medical Examiners in Tallahassee.

RVS Changes

The FMA Board of Governors has approved two changes in the 1971 Florida Relative Value Studies on the basis of re-surveys by the Committee on RVS.

The changes are:

1. Procedure 61380—Lobotomy, including cingulotomy, should be changed to a BR, "By Report," item.
2. Procedure 59400—Total obstetrical care including antepartum care, vaginal delivery and postpartum care (with or without low forceps and/or episiotomy) should be changed to 12.0 units.

Physicians are asked to mark the changes in their copies of the RVS.

Dr. Papper Heads U.S. Delegation

E. M. Papper, M.D., Dean of the University of Miami School of Medicine, has been appointed Chairman of a scientific mission to China.

Dr. Papper is chairman of a delegation of nine physicians and biomedical scientists that is supposed to evaluate the use of acupuncture in surgical anesthesia. The delegation planned to depart for China about May 1.

The Miami Dean was appointed to the post by the National Academy of Sciences and two other organizations which form an advisory committee to the U.S. Government.

Heart Research Grants

The Florida Heart Association is now receiving applications for grants-in-aid for research in the cardiovascular field and in related problems in the basic sciences.

Applicants must have a doctoral degree, e.g., M.D., Ph.D., D.D.S., or the equivalent. Applications must be postmarked on or before July 15, 1974. Projects will be funded in January, 1975.

Information and application forms may be obtained from the Florida Heart Association, P.O. Box 10100, St. Petersburg, Fla. 33733.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

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(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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acute gonorrhea

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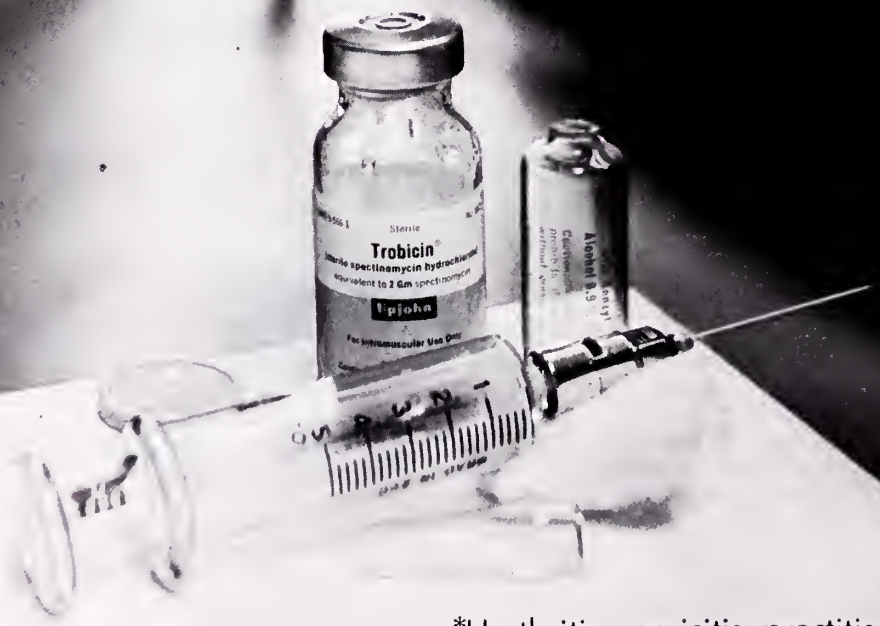

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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Because many patients tend to stop treatment prematurely, the full course of b.i.d. therapy is now specially packaged to encourage patients to complete the full course of therapy.

CANDEPTIN Vaginal Ointment Therapy Pack—two 75 gm. tubes
CANDEPTIN Vagelettes Therapy Pack—28 vaginal capsules
CANDEPTIN Vaginal Tablet Therapy Pack—28 vaginal tablets

Brief Summary

Description: CANDEPTIN (Candicidin) Vaginal Ointment contains a dispersion of Candicidin powder equivalent to 0.6 mg. per gm. or 0.06% Candicidin activity in U.S.P. petrolatum. 3 mg. of Candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candicidin powder equivalent to 3 mg. (0.3%) Candicidin activity dispersed in starch, lactose and magnesium stearate.

CANDEPTIN VAGELETTES Vaginal Capsules contain 3 mg. of Candicidin activity dispersed in 5 gm. U.S.P. petrolatum.

Action: CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGELETTES Vaginal Capsules possess anti-monilial activity.

Indications: Vaginitis due to *Candida albicans* and other *Candida* species.

Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETTES Vaginal Capsules have been extremely rare.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETTES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Available Dosage Forms: CANDEPTIN Vaginal Ointment is supplied in a Patient Therapy Pack, containing two 75 gm. tubes with two applicators for the full course of treatment. CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN Vagelettes Vaginal Capsules are packaged in a Patient Therapy Pack, containing 28 CANDEPTIN Vagelettes Vaginal Capsules (2 boxes of 14), for the full course of treatment. Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

References:

1. Melges, F. J.: Obstet. Gynecol. *24*:921, Dec. 1964. **2.** Cameron, P. F.: Practitioner *202*:695, May 1969. **3.** Olsen, J. R.: Journal-Lancet *85*: 287, July 1965. **4.** Giorlando, S. W.: OB/GYN Digest *13*:32, Sept. 1971. **5.** Decker, A.: Case Reports on file, Medical Department, Julius Schmid. **6.** Friedel, H. J.: Md. State Med. J. *15*:36, Feb. 1966. **7.** Roberts, C. L. and Sullivan, J. J.: Calif. Med. *103*:109, Aug. 1965. **8.** Giorlando, S. W., Torres, J. F. and Muscillo, G.: Am. J. Obstet. Gynecol. *90*:370, Oct. 1, 1964. **9.** Abruzzi, W. A.: Western Med. *5*:62, Feb. 1964.

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- Sensitivity and temporary irritation with CANDEPTIN (candicidin) Vaginal Ointment, Vaginal Tablets, and VAGELETTES Vaginal Capsules have been extremely rare.

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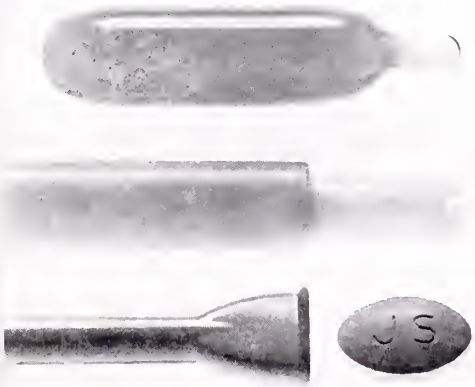

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Vaginal Tablets

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PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

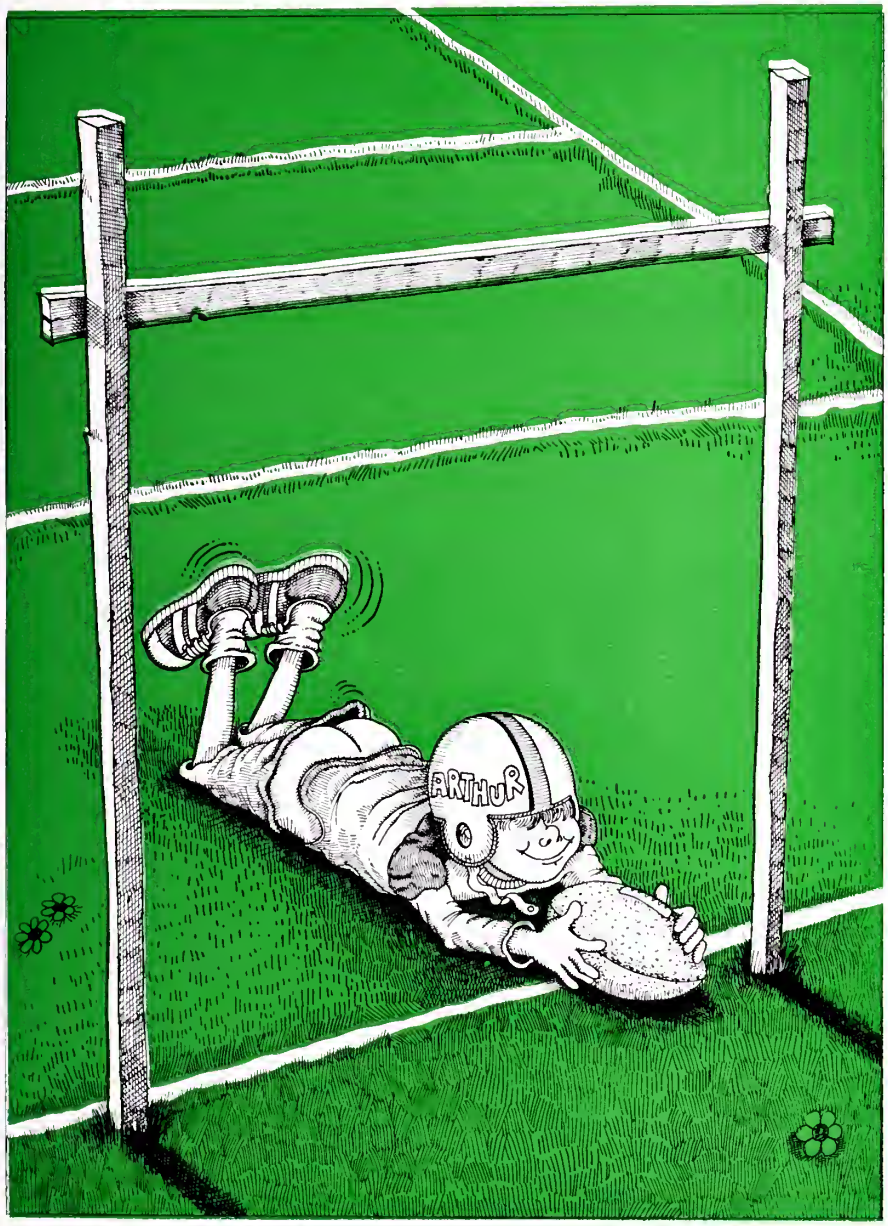
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

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Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

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October 6-19, 1974

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This course is designed primarily for internists who are preparing for certifying examinations. It is intended to provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Each subspecialty will be reviewed as described under "Schedule." Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Summaries and references will be provided to all registrants, and audio-visual teaching aids will be available during the course for self-instruction and reinforcement.

Schedule:

The course will consist of daily sessions, Monday through Saturday for two successive weeks. On each day beginning at 8:00 a.m., fundamental and core material on a given topic will be presented. After a coffee break (10:00-10:30 a.m.), recent advances will be reviewed from 10:30 a.m. to 1:30 p.m.; from 5:00 p.m. to 7:00 p.m., there will be amply illustrated reviews on such relevant topics as ophthalmologic, endoscopic, dermatologic, radiologic, etc., manifestations of internal diseases.

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A limited number of suites at the Sheraton-Four Ambassadors Hotel have been made available at a special rate of $19/28 per day. A hotel reservation form will be promptly forwarded with the confirming registration.

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Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

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When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

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Delivers from the very first dose:

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#3, codeine phosphate* (32.4 mg.) gr. ½
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Iron (from Ferrous Sulfate)	2.82 mg.
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg.
Ascorbic Acid	25.0 mg.
Folic Acid	0.1 mg.
Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inositol	10 mg
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg.
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.
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ACTION AND USES—*DOSAGE:* 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. *PRECAUTIONS:* Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. *CONTRAINDICATIONS:* Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. *AVAILABLE:* Bottles of 30, 100, and 500 tablets.
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JUNE, 1974 • VOLUME 61 • NUMBER 6

Adult Respiratory Distress Syndrome

Report of 18 Cases

ANONG CUTCHAVAREE, M.D. AND MARVIN A. SACKNER, M.D.

Abstract: The Adult Respiratory Distress Syndrome (ARDS) is marked by severe dyspnea, tachypnea and hypoxemia refractory to oxygen therapy; it is accompanied by roentgenographic evidence of diffuse pulmonary edema unrelated to cardiac failure. The causes for this syndrome in 18 patients included aspiration pneumonia, viral pneumonia, septicemia, shock, smoke inhalation, fat emboli, sea water drowning and drug overdosage. The decision to support the patient during the acute phase of the illness by modalities of supplemental oxygen therapy, intermittent positive pressure breathing with large tidal volumes, or positive end expiratory pressure breathing is based upon the clinical status and the desire to minimize inspired oxygen concentration while still maintaining an adequate arterial oxygen tension of between 60 to 80 mm Hg. Survival in the acute phase is significantly higher in patients younger than 59 years (88%) than those who are older (33%).

In recent years, descriptions have appeared of patients with severe dyspnea, tachypnea, and hypoxemia refractory to oxygen therapy who during their clinical course developed roentgenographic evidence of diffuse pulmonary edema unrelated to cardiac failure. This condition has been called the Adult Respiratory Distress Syndrome (ARDS) although terms such as "Wet Lung," "White Lung Syndrome," "Shock Lung" and "Congestive Atelectasis" have also been applied.[1-3] It is usually associated with both thoracic and nonthoracic trauma, drug ingestion, aspiration, pancreatitis, burns and viral pneumonia. Ancillary factors that may contribute to its establishment include shock, acidosis and excessive infusion of blood and fluids. In the absence of treatment, mortality is stated to be greater than 70% while with optimal present day therapy mortality has been lowered to about 25%.[4] The purpose of this paper is to report our experience with this condition.

Clinical Features

PATIENT SELECTION. Over a 30 month period from 1971 to 1973, we treated 18 patients, ages 18 to 75 years with the diagnosis of ARDS (Table 1). All patients had the typical clinical and roentgenographic signs of ARDS and showed an arterial oxygen tension of less than 60 mm Hg while breathing concentrations of 50% inspired oxygen or higher.

ETIOLOGY AND CONTRIBUTING FACTORS. The precipitating causes in our patients include aspiration pneumonia 5 cases, viral pneumonia 5 cases, septicemia 2 cases, shock 2 cases, smoke inhalation 1 case, fat emboli 1 case, drug overdose 1 case, and sea water drowning 1 case (Table 1).

COMPLICATIONS. The complications during acute course of the illness included renal failure in 5 cases (28%), anemia in 5 cases (28%), gastrointestinal bleeding in 3 cases (17%), pneumo-

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Table 1.—Characteristics of Patients With ARDS.

Pt. No.	Age	Sex	Etiology & Contributing Factors	Complications	Steroid Therapy	Days Hospitalized	Survived	Died During ARDS	Died After ARDS
1	53	M	Viral pneumonia	Renal failure, anemia	+	34	+		
2	65	F	Aspiration pneumonia	Tracheal stenosis	+	25	+		
3	60	F	Viral pneumonia	Perforated duodenal ulcer	+	17		+	
4	18	M	Septicemia, sickle cell trait	Pneumothorax, anemia	+	52	+		
5	52	F	Pulmonary emboli	Renal failure, anemia	0	94	+		
6	57	F	Shock, oxygen toxicity	Candida endocarditis	+	100			+
7	58	M	Aspiration pneumonia	Renal failure, tracheal stenosis	+	94	+		
8	75	M	Aspiration pneumonia, shock, oxygen toxicity	Gastrointestinal bleeding	+	70			+
9	79	M	Aspiration pneumonia	Pneumothorax	+	16		+	
10	65	F	Smoke inhalation	Staphylococcal septicemia and pneumonia	+	14		+	
11	81	M	Drowning	Pseudomonas pneumonia	0	30	+		
12	41	F	Viral pneumonia	Tracheal stenosis	+	40	+		
13	72	M	Viral pneumonia	Gastrointestinal bleeding	+	36	+		
14	67	F	Shock, aspiration pneumonia	Gastrointestinal bleeding, renal failure	+	50		+	
15	39	M	Viral pneumonia	None	+	11	+		
16	47	F	Drug overdose	Pancytopenia, tracheal stenosis	+	50			+
17	57	M	Septicemia	Renal failure, hepatic failure	0	50		+	
18	28	M	Fat emboli	Anemia	0	9	+		

thorax 2 cases (11%), perforated duodenal ulcer 1 case (6%), hepatic failure 1 case (6%) and staphylococcal septicemia 1 case (6%) (Table 1). Tracheal stenosis occurred during the convalescent phase in 4 cases (22%).

Steroid Therapy. Fourteen of the 18 patients received intravenous hydrocortisone over two to 16 day periods in amounts ranging from 300 mg to 4,000 mg per day. The average duration of this treatment was five days and the average daily dose was 1200 mg (Table 1). No difference in survival rates or complications could be ascribed to the usage of steroids.

Days Hospitalized. Hospitalizations were prolonged (8 to 100 days) and were related to the slow resolution of the disease process in the lungs as well as the complications that accompanied ARDS (Table 1).

Survival. Ten patients survived ARDS (Table 1). This amounted to 56% for the entire group or 67% if the patients who died during convalescence were excluded from the statistics. The latter included three patients who died after resolution of the ARDS from nonpulmonary causes. In two of these three postmortem examinations, the lungs revealed evidence of marked pulmonary fibrosis. In three of the five patients who died during the course of ARDS, postmortem examination revealed heavy congested lungs whose surfaces appeared relatively dry on cut section. Microscopic sections showed alveolar spaces filled with fluid, macrophages and pneumocytes, thickening of the alveolar septae and scattered hyaline membranes. The immediate survival rate from ARDS in patients less than 59 years was 88% (7 of 8 patients) whereas in patients greater than 60 years of age, it was only 33% (2 of 6 patients).

Arterial Blood Gases. Because of the acute respiratory distress manifested by our patients it was possible to obtain arterial oxygen tensions breathing room air on only three patients (Table 2). These values ranged from 21 to 42 mm Hg. In one patient breathing 100% O_2 by intermittent positive pressure breathing, the arterial pO_2 was only 34 mm Hg (case 6). In all patients adequate levels of arterial oxygen tension during the acute phase of the illness were achieved by raising inspired oxygen concentration or using intermittent positive pressure breathing with or without positive end expiratory pressure (Table 2). In no instance did retention of carbon dioxide occur during spontaneous breathing; in most instances, a mild to moderate respiratory alkalosis was found. The average respiratory frequency was 37 per minute with a range of 28 to 64 respirations per minute.

Table 2.—Arterial Oxygen Tension in ARDS.

Patient	Lowest PaO_2 mmHg	O_2 Administration	Highest PaO_2 mmHg (In acute period)	O_2 Administration
1	21	21%	120	40% — 10cmH_2O PEEP
2	36	70% IPPB	98	40% — 12cmH_2O PEEP
3	38	100% IPPB	163	100% — 10cmH_2O PEEP
4	32	21%	205	80% — 8cmH_2O PEEP
5	50	100%	102	80% — 10cmH_2O PEEP
6	34	100% IPPB	210	100% — 10cmH_2O PEEP
7	49	100%	63	100% — 10cmH_2O PEEP
8	48	70% IPPB	65	100% — 8cmH_2O PEEP
9	27	70%	125	80% — 8cmH_2O PEEP
10	50	50% IPPB	130	50% — 10cmH_2O PEEP
11	41	60%	109	100% — 15cmH_2O PEEP
12	47	70%	67	60% — 10cmH_2O PEEP
13	42	60%	67	70% — IPPB
14	49	70%	129	50% — IPPB
15	47	50%	82	60% — IPPB
16	44	50% IPPB	147	80% — IPPB
17	58	50%	116	50% — IPPB
18	42	21%	112	60%

THERAPY. This was directed toward improving systemic oxygenation to provide support while the injury to the lung that initiated ARDS resolved. It was achieved by increasing inspired oxygen concentrations or employing intermittent positive pressure breathing (IPPB) with oxygen and large tidal volumes as supplied by a volume-limited respirator or by adding positive end expiratory pressure (PEEP) to IPPB. The decision to use one of the preceding modalities was based upon the clinical status of the patient and the desire not to employ concentrations of oxygen greater than 80% for 24 to 36 hours because of the risk of pulmonary oxygen toxicity. When arterial oxygen tension was raised by increased oxygen concentrations and/or intermittent positive pressure breathing with large tidal volumes, the patient usually remained tachypneic and restless. However, the addition of PEEP (Fig. 1) to mechanical ventilation often had a calming effect and the respiratory rate usually diminished dramatically. In the first three patients treated with PEEP, we used curare to paralyze the thorax to permit the respirator to control respirations. Curarization (3 to 6 mg every 15 to 30 minutes) produced marked fluctuations in blood pressure and interfered with clinical evaluation of the course of disease. For example, one of our patients developed peritonitis due to a perforated duodenal ulcer which was unrecognized until postmortem examination. The next eight patients in whom PEEP was employed were treated by setting the sensitivity control of the mechanical respirator we used (Bennett MA-1) to a point where the patient could assist just below the level of PEEP (Fig. 2) or be controlled if his respiratory efforts were too weak. This technique was much more satisfactory than curarization. PEEP was adjusted upwards in steps from 5 cm H_2O to 15 cm H_2O pressure by continuously monitoring systemic blood pressure and decreasing its level if there was a significant fall in this parameter. Arterial blood oxygen tension was measured and PEEP was adjusted to give an optimal value at the lowest inspired oxygen concentration possible.

CHEST ROENTGENOGRAMS AND CLINICAL COURSE. These are summarized in three representative cases by Figures 2 to 6.

Discussion

The Adult Respiratory Distress Syndrome (ARDS) develops as a nonspecific response to a variety of pulmonary injuries. The ultimate out-

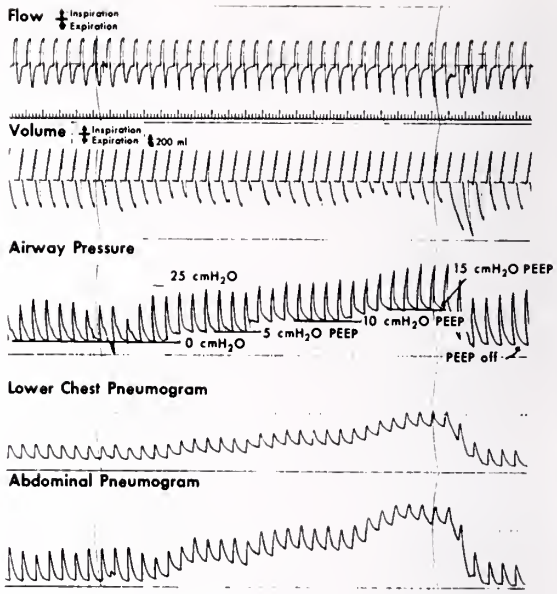

Fig. 1a

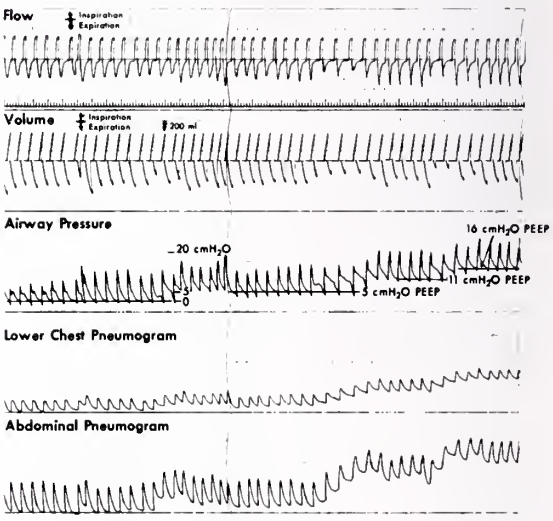

Fig. 1b

Fig. 1.—Effects of PEEP in a normal volunteer. A pneumotachograph was interposed between the mouthpiece and the respirator. Flow was recorded in the uppermost tracing, and then integrated electrically to give volume. Airway pressure was recorded from a strain gauge. Whitney mercury in silastic strain gauges were placed about the lower chest and upper abdomen to give a pneumotachographic estimate of change in girth of the thorax and abdomen. (A) Controlled respiration with various levels of PEEP. In this circumstance, the respirator initiates each tidal breath. The increase in volume of the thorax and abdomen with increasing levels of PEEP is evident. (B) Assisted respiration with various levels of PEEP. In this circumstance, the subject initiates each tidal breath. The respirator is set to trigger when the airway pressure falls about 1 to 2 cm H_2O below the level of PEEP. Thus, a deflection below the level of PEEP can be seen on the record of airway pressure. Nevertheless, the increase of girth of the thorax and abdomen in the pneumographic recordings does not differ from the recording obtained during controlled respiration.

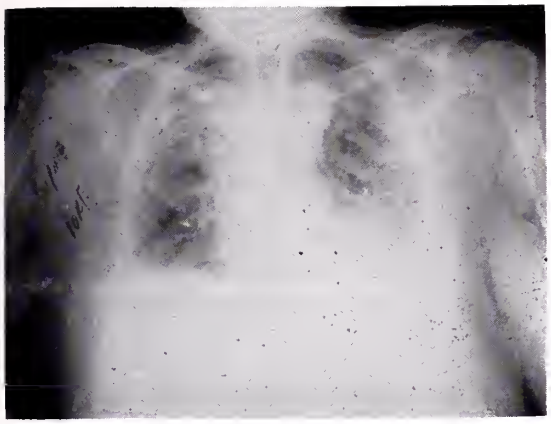

Fig. 2a

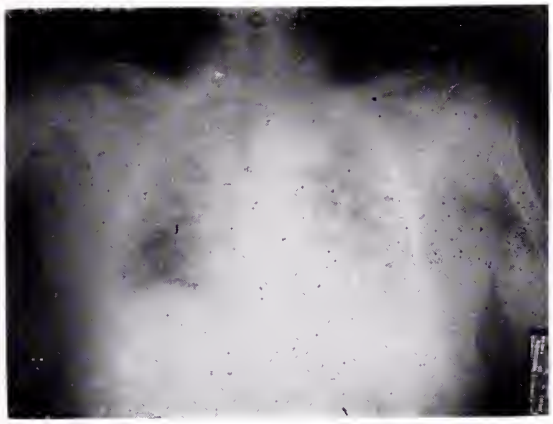

Fig. 2b

Fig. 2.—Chest roentgenograms in case 3, a 60-year-old woman with viral pneumonia. A. Day 1 (of onset of ARDS). This shows a pulmonary edema-like picture. B. Day 3. Immediately prior to PEEP with worsening of the pulmonary edema.

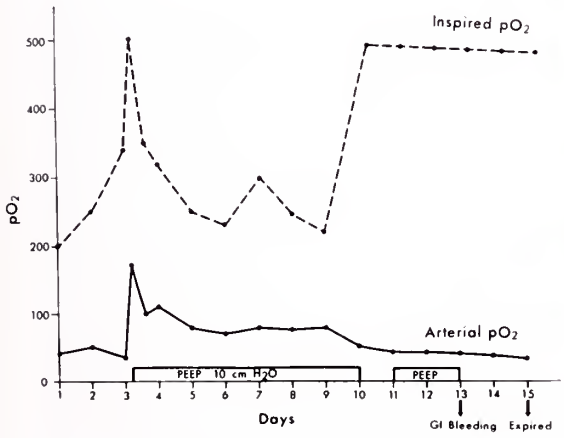

Fig. 3.—Clinical course of case 3 (Figure 2).

Fig. 4a

Fig. 4b

Fig. 4.—Chest roentgenograms in case 4, an 18-year-old man with septicemia and sickle cell trait. (A) Five days prior to development of ARDS at the time that acute appendicitis was present. (B) Day 1 of ARDS. This shows diffuse alveolar infiltrates.

Fig. 4c.—Thirty days after onset of ARDS. This shows almost complete clearing of alveolar infiltrate.

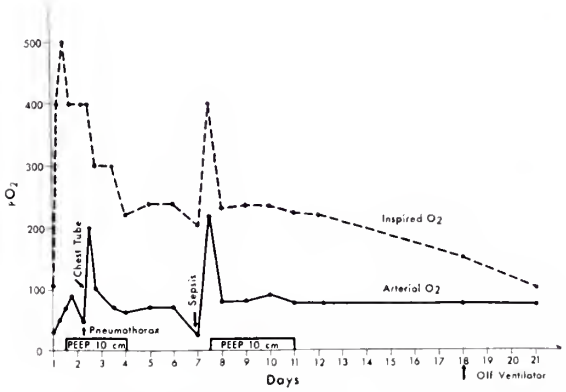

Fig. 5.—Clinical course of case 4.

come is dependent upon three factors: (1) the extent of original injury, (2) the effectiveness of respiratory support and (3) the prevention of further injury. Iatrogenic fluid overload may worsen the condition. Renal insufficiency as a result of clinical shock that often occurs during the initial insult further complicates the management of these patients. Once the alveolo-capillary membrane is injured, and vascular integrity lost, expansion of the circulating blood volume causes outpouring of fluid into the alveoli and impaired oxygen transport.[1,2]

A major therapeutic consideration in ARDS is the relief of the marked hypoxemia that accompanies it. This necessitates increasing the inspired oxygen concentation above that of room air. However, it has long been recognized that the breathing of oxygen itself for long periods produces lung injury and cases have been reported in which O_2 itself has been incriminated as a cause of ARDS.[5] Recent observations in our laboratory indicate that there is significant suppression of mucous clearance in the trachea of normal volunteers after breathing O_2 for only six hours. Furthermore, a tracheitis can be directly observed by bronchofiberscopy in these subjects.[6] These noxious effects of O_2 might lead to superimposed bacterial infection through suppression of this mechanism of host defense and could be the direct cause for the commonly observed sepsis that often is associated with ARDS.

Intermittent positive pressure breathing with a large tidal volume may relieve the hypoxemia at lower inspired O_2 concentrations than is possible during spontaneous breathing. This is because the level of functional residual capacity (lung volume at the end of a normal expiration) is reduced in ARDS and the large tidal volumes produced by the respirator help to open airways that close at low lung volume but whose parenchymal units are still perfused. This opening of atelectatic areas by the respirator helps to relieve the right to left intrapulmonary shunt and thereby improves systemic oxygenation. However, this technique may not be always effective. It has been improved by the addition of positive pressure through the whole of expiration (positive end-expiratory pressure—PEEP). The latter satisfactorily enables oxygenation of the blood (pO_2 of 60 to 80 mm Hg) at lower inspired oxygen concentrations than is possible with the use of large tidal volumes. For those patients who fail to attain satisfactory arterial oxygen tensions on PEEP, the membrane oxygenator has been employed by some investigators as a prolonged bypass support device.[7] However, in none of our patients have we failed to achieve satisfactory levels of arterial oxygenation with PEEP. Nevertheless, PEEP is not without complications: significant tracheal stenosis developed in four of our 18 patients probably due to the high cuff volumes of the tracheostomy tube to maintain a seal because of the large inflation pressures necessary to expand the lungs and provide adequate ventilation. Respiratory support by membrane oxygenators might lower the incidence of this complication provided these devices are safe to employ.

Fig. 6a

Fig. 6b

Fig. 6.—Chest roentgenograms in case 16, 28-year-old man with fat emboli following a fracture of the leg. (A) Second day after the accident. Lung fields are clear but patient was breathless and cyanotic, (B) Fifth day after accident. This shows fluffy alveolar infiltrates consistent with fat emboli.

PEEP is used in conjunction with mechanical ventilation in adults although in infants it may be employed during spontaneous breathing. In our initial trials with PEEP, we controlled the respirations by administration of curare but have found it much more convenient to let the respirator assist the patient's respiration after adjusting the sensitivity control of the respirator so that the inspiratory cycle was initiated just below the level of PEEP. In every patient in whom we employed PEEP, there was a significant rise in arterial oxygen tension with little or no fall in mean arterial pressure. Others have shown that PEEP usually does not lower the cardiac output in patients with ARDS.[8,9] However, in other pulmonary syndromes with depressed arterial oxygenation such as status asthmaticus and chronic obstructive lung disease, PEEP may produce a significant fall in cardiac output, and a high propensity to pneumothorax. Therefore, PEEP is contraindicated in these conditions.[10] The reason why PEEP does not usually produce a fall in cardiac output is related to the stiff lungs (low lung compliance) found in ARDS. The alteration in this mechanical characteristic of the lung results in restriction of the positive end expiratory pressure to the pleural space because of its dissipation in overcoming alveolar surface tension forces or passing through the progressive resistances of fluid-filled alveolar and bronchiolar ducts.[9] Since pleural pressure during PEEP is minimally affected, venous return is not restricted.

PEEP appears to produce an increase in arterial oxygenation by opening up atelectatic alveoli which are being perfused by pulmonary arterial blood. The improvement in arterial oxygen tension begins within five minutes and approaches a maximum between 15 and 60 minutes. There is no set level of PEEP that is optimal. In some patients, lower levels give better oxygenation than higher levels. Most patients with ARDS seem to do well between 8 to 12 cm H_2O. As the patient improves, inspired O_2 concentrations are brought to levels below 50% before reducing the level of PEEP. The gradual improvement in oxygenation that occurs during the course of PEEP is probably due to resolution of intra-alveolar fluid as the

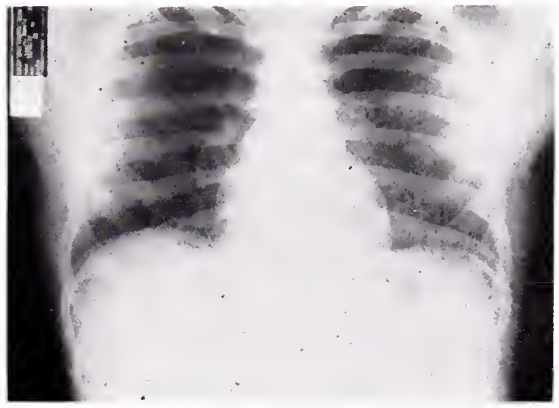

Fig. 6c.—Ninth day after accident. Almost complete resolution of fat emboli is seen.

injury to the alveocapillary membrane heals. If the injury does not heal, then arterial oxygen tension continues to fall despite the employment of PEEP with high inspiratory oxygen concentrations, and, is a poor prognostic sign.

The present series included a significant number of patients older than 60 years of age. The difference in immediate survival to ARDS between the younger and older patients was striking. In patients younger than 50 years, there was an 88% survival whereas in patients older than 60 years, the survival was only 33%.

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Physician's Duty to Assist Patient In Obtaining Medical Insurance

A physician is under a duty to his patient to use reasonable care to fill out and mail a physician's statement necessary for the patient to obtain a health insurance policy, a Delaware court held. Failure of the physician to properly dispose of the form will render him personally liable for any medical expenses suffered by the patient as a result of his not being medically insured, if it can be shown that the physician's failure to forward the physician's statement was the direct cause of the insurance company's refusal to issue a policy to the patient.

In this case the defendant was an obstetrician who had treated the patient, a pregnant woman, for a kidney infection and anemia. After her discharge from the hospital, she and her husband decided to obtain family health insurance coverage. The defendant was named on the form as having treated the patient's kidney infection; consequently the insurance company sent him a routine form known as an "attending physician's statement," which the physician apparently filed and forgot. The insurance company wrote the patient and declined the application for insurance because the underwriting statement had not been received. When, prompted by complaints from the patient, the physician finally sent in the form, the patient and her husband had incurred considerable medical expenses for which the insurance company declined to reimburse them.

Their suit charged the defendant with negligence and the court held the patient's complaint stated a good cause of action and refused to dismiss the suit.

Murphy v. Godwin
303 A.2d 668
February 15, 1973

This judicial decision dramatically emphasizes what numerous courts have stated in various jurisdictions on many occasions; namely, that a physician has a legal (as well as a moral and ethical) duty to legitimately assist his patient in procedural matters of a legal nature when only he, as the treating physician, can accomplish certain things that the patient is obliged to do within the civil legal processes.

Reprinted from MXR (Malpractice X-posure Reports), Vol. 3, December 1973.

A Survey of Respiratory Care Resources in Florida

Gerald N. Olsen, M.D., Anthony J. Lucas, B.S.E.E.,
Carl C. Booberg, B.A., and Albert P. Foster, M.A.

Abstract: To determine the prevalence of respiratory disease in Florida and the institutional facilities available for its management, a study was done utilizing a review of existing mortality statistics, an in-person survey of personnel of selected hospitals, a mail survey of selected nursing homes, and an on-site visit of five selected hospitals. The review of the mortality statistics reveals that respiratory disease is the 4th leading cause of death, with chronic obstructive pulmonary disease (COPD) the 6th leading and fastest-rising cause of death in Florida. The survey revealed that the greatest need in respiratory care in Florida is the creation of active hospital-based respiratory care services under the supervision of a skilled physician-director. Nursing homes appear to be utilized infrequently for respiratory care and, concomitantly, have a low level of specialized resources for this purpose.

In Florida, there are approximately 7¼ million people. The state registers a gain of about 12,000 immigrants per month. Since a significant proportion of these people are elderly, their medical problems are deserving of special attention, especially chronic respiratory disease.

To better acquaint the medical community interested in respiratory disease with the impact of this problem, data were needed concerning the extent of the problem and the resources available to meet the challenge. This study was performed to obtain these data.

Materials and Methods

The study consisted of an examination of: (1) extent of the COPD problem in Florida, (2) hospital-based resources available, and (3) nursing home resources available. To obtain the necessary data, three techniques were used: review of mortality data from the Florida Division of Health, survey of selected general hospitals and nursing homes, and visits to selected general hospitals.

Mortality Data

A vital statistics summary was obtained from the Florida Division of Health covering the previous year January-December 1971. Data concerning the death rate from respiratory disease were extracted and compared with similar data on other diseases of the aged, e.g., cancer, cardiovascular, and cerebrovascular. The death rates were also compared with similar data of ten years ago to assess the relative importance of respiratory disease as a cause of death in Florida as well as trends in death rates. To compare Florida with the U.S. in general, mortality data were obtained from the U.S. Department of Health, Education and Welfare.

Hospital Survey

A questionnaire was used on a personal-interview basis with 80 hospitals having a capacity in excess of 150 beds. The larger hospitals were selected as those most likely equipped and staffed to handle acute respiratory failure patients.[1] While a simple catalogue of which hospital had which resources would be of interest, it would not lead to a delineation of problems as well as a smaller sample would when studied quantitatively for comparisons and trends.

Initial information of the hospitals was obtained from the "Listings of Health Care Institutions."[2] These hospitals were located in 24 (35%) of Florida's 67 counties and contained 28,269 (60%) of the 47,119 total hospital beds

From the Department of Medicine, University of Florida College of Medicine, Gainesville.
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Endorsement of the study was received from the Florida Nursing Home Association.
Direct reprint requests to the Florida Lung Association, P.O. Box 8127, Jacksonville 32211.

in the state. Because respiratory disease is usually treated in the general hospital, only those hospitals with classifications as general medical and surgical, or tuberculosis and respiratory disease were selected. With the elimination of the nonrespiratory specialized hospitals, general hospitals containing 83% of the beds expected to treat respiratory disease were surveyed by questionnaire.

The questionnaire was adapted from one developed by the National Tuberculosis and Respiratory Disease Association in October 1971. It contained 139 questions divided into five sections: Hospital Administration, Pulmonary Disease-Respiratory Care Service, Intensive Care, Inhalation Therapy, and Physical Therapy. The questions were designed to be answered by "yes," "no," a name or a number for ease of conversion to computer cards.

A personal interview technique was selected to improve the quality and quantity of the anticipated data. The personnel were lay volunteers from the Florida TB-RD Association and its affiliates. An orientation session acquainted them with the survey form, terminology, and interview technique. Interviewers were instructed to seek out the individuals in the hospitals having the greatest responsibility for each of the five sections of the questionnaire.

A computer program was written to quantify the data from the questionnaires. The program was written for the IBM 370 computer on the University of Florida Campus in PL-1 computer language. The responses from the questions were converted to IBM computer cards for permanence and for ease of handling.

During the survey the project director visited five hospitals in or near large metropolitan areas. These are designated as hospitals "A" through "E".

Nursing Home Survey

Data concerning respiratory patients in nursing homes, and the available resources for treatment, were also obtained through use of computer quantification of the responses to a questionnaire. Fifty nursing homes having a capacity in excess of 125 beds were selected from the list of nursing homes licensed through the Bureau of Health Facilities of the Florida Division of Health. Only those characterized as "Comprehensive Nursing Care" nursing homes were surveyed. The homes selected represented ten (22%) of Florida's 67 counties, 9,583 (37%) of the 25,586 total nursing home beds, and 19% of the 269 nursing homes in the state.

The nursing home questionnaire was created *de novo* since a prototype was not known to exist. It contained 30 questions answerable by "yes," "no," a name or a number. The questions involved the number of staff, numbers of patients with different diagnoses, and the basic facilities used to manage respiratory disease. These questionnaires were mailed to the nursing homes with addressed, stamped, return envelopes.

A computer program similar to that previously described for the hospitals was written. The responses from the questionnaires were converted to IBM computer cards for ease of handling.

Results and Discussion

Mortality Data

According to figures obtained from the U.S. Department of Health, Education and Welfare, 9.4% or almost one in ten Floridians died directly of respiratory disease in 1971. This does not include those with other diseases such as trauma, strokes, heart attacks, etc., who died in respiratory failure. If all respiratory diseases are considered together, then respiratory disease becomes the 4th leading cause of death in Florida following diseases of the heart, nonrespiratory malignant neoplasms and cerebrovascular disease. The most frequent cause of respiratory death appears to be respiratory system neoplasm with 3,664 deaths. The most frequent non-neoplastic respiratory disease is pneumonia with 2,038 deaths. The second most frequent is chronic obstructive pulmonary disease (COPD) which consists of bronchitis, emphysema, and asthma with 1,443 deaths. Considered alone, COPD is ranked as the 6th leading cause of death (Table 1). It is well known, however, that mortality statistics derived from death certificates are often inaccurate, especially in the case of COPD[3], in which the terminal event of long-standing disease may occur as respiratory failure during an episode of influenza.

Statistics of ten years ago indicate that COPD ranked 12th in overall mortality in comparison to the data for 1971 which shows COPD as the 6th leading cause of death. This rise is the fastest of all the diseases listed and may be related to two major factors: these diseases are being more frequently diagnosed and, therefore, coded on death certificates; and smoking continues to increase among all age groups.

In comparing the statistics available for Florida with those for the U.S. in general (Table 2),

it is apparent that 8.7% of the people dying in the U.S. succumbed to combined respiratory causes. In the U.S., however, COPD ranks as the 9th leading cause of death as compared to the 6th in Florida. This difference suggests that Florida has a higher relative mortality rate from COPD than does the U.S. in general.

General Hospital Survey

Two hospitals refused to be surveyed and one answered only the hospital administration questions. The responses of 78 (97%) of the 80 hospitals cover 27,819 (59%) of the state's hospital beds. The annual admissions represented total 914,596 and the average bed capacity was 357.

An average of 7% of the beds were occupied daily by patients with the primary diagnosis of respiratory disease which was about 25 patients per hospital per day; 22 of the 78 hospitals (28%) did not know how many respiratory disease patients had been admitted.

Of the patients admitted, 3% were discharged with the primary diagnosis of COPD and 2% with the secondary diagnosis of COPD. This suggests that of every seven respiratory disease patients occupying a hospital bed, three had COPD as their primary disease.

Pulmonary Disease-Respiratory Care Service

Only 53% of the hospitals had an organized pulmonary disease or respiratory care service. Of those hospitals which did not have an organized service, 70% had a physician who assumed primary responsibility for this service. Sixty-nine percent of these physicians are employed full time by the hospital—50% are anesthesiologists and 35% are internists by training. Fifty-one percent of the hospitals not having an organized pulmonary disease-respiratory care service do not have plans to develop one.

Of those hospitals which did have an organized service, there was an average of four physicians on this service. From the survey, it appears that considerable physician training is being performed on some of these services inasmuch as there was a total of 58 physicians (30 residents, 13 interns, 15 fellows) assigned to these services.

Diagnostic Testing

Sixty-eight percent of the hospitals had a pulmonary function laboratory; of those which did not have one, only 36% did not have plans to develop one. Of these pulmonary function laboratories, 89% had a physician director and the average number of technicians assigned was four.

Table 1.—Ten Leading Causes of Resident Deaths and Death Rates Per 100,000 Population, Florida, 1971 and 1961.

Rank		Cause of Death	Deaths		Rates	
1971	1961		1971 Total	1961 Total	1971 Total	1961 Total
1	1	Diseases of the Heart	27,227	17,586	388.3	338.9
2	2	Malignant Neoplasms	14,280	8,233	203.3	158.7
3	3	Cerebrovascular Disease	8,618	5,660	122.7	109.1
4	4	All Accidents	4,218	2,839	60.0	54.7
5	6	Influenza and Pneumonia	2,073	1,242	29.5	23.9
6	12	Bronchitis, Emphysema, Asthma	1,443	624	21.3	12.0
7	5	Diseases of Early Infancy	1,381	2,034	19.7	39.2
8	11	Cirrhosis of Liver	1,309	591	18.6	11.4
9	8	Diabetes Mellitus	1,293	753	18.4	14.5
10	7	Arteriosclerosis	1,062	843	15.1	16.2
11	9	Suicide	982	664	14.0	12.8

Table 2.—Deaths from Respiratory Diseases per 100,000 Population in 1971.

	United States	Florida
Total Deaths, All Causes	940.4	1,079.9
Tuberculosis, All Forms	2.7	2.6
Malignant Neoplasms, Respiratory System	33.9	52.2
Acute Bronchitis and Bronchiolitis	0.5	0.4
Influenza and Pneumonia	30.5	29.5
Bronchitis, Emphysema, and Asthma	14.9	21.3
Total Deaths, Respiratory	82.5	105.2

Pulmonary function studies of clinical usefulness consist of spirometry, lung volume determination, diffusing capacity determination, and arterial blood gases. Of the hospitals surveyed, 77% perform spirometry, averaging ten per week; 67%, lung volume measurements, averaging five per week; and only 26% are able to perform diffusing capacity determinations which average nine per week. Only 24% of the hospitals surveyed can do all three of these determinations. Arterial blood gas determinations, considered critical in the care of respiratory patients, are performed by 92% of the hospitals, 24 hours a day, and average 54 determinations per week. Seventy-two percent stated that they have back-up instrumentation to provide this service in the event of a breakdown.

Other diagnostic tests are available at most of the hospitals surveyed. Of the radiologic tests, 65% perform routine admission chest x-rays; 87%, fluoroscopy; 82%, laminography; 90%, bronchography; 69%, pulmonary angiography; 82%, radioisotope lung scans; and 14% stated that they could perform ^{133}Xenon ventilation-perfusion scans. Forty-two percent of the hospitals had facilities to perform cardiac catheterizations.

In basic clinical laboratory studies, 97% of the hospitals had the capacity to do bacteriologic smears, cultures and antibiotic sensitivity studies. Ninety-six percent were able to do electrolyte determinations and 99% had a laboratory operating 24 hours a day.

Emergency Facilities

Ninety-four percent of the hospitals reported having an emergency room open 24 hours a day equipped to handle patients in acute respiratory failure, and 385 patients per hospital per year were treated. Eighty-six percent of the hospitals have a physician always on call in the hospital and 11% have a nurse skilled in respiratory emergency procedures always immediately available.

Outpatient Services

Twenty-four percent of the hospitals stated that they sponsor a pulmonary disease outpatient clinic of which 89% have a physician in charge. Of some surprise is the fact that only four patients per week were treated in these clinics. In spite of this low figure, 39% of the hospitals not having such a pulmonary disease clinic plan to develop one!

While only 24% of the hospitals sponsor a clinic for respiratory patients, 79% have outpatient intermittent positive pressure breathing (IPPB) treatments available; however, only 18% stated that they use postural drainage with the treatments. Forty-seven percent stated that they give their patients instruction in home respiratory physical therapy together with outpatient treatments.

Questions were asked concerning home visits made by nurses, inhalation therapists, or physical therapists. The responses revealed that 6% of the hospitals have home visits by nurses, 10% by inhalation therapists and 8% by physical therapists.

Respiratory Care Training

Eighty-five percent of the hospitals have an in-service training program with someone responsible for this service. Fifty percent have a training program for physicians, 81% for registered nurses, 74% for licensed practical nurses, 82% for inhalation therapists, and 33% for physical therapists. Only 32% stated that they conducted their training along the "team" approach, i.e., simultaneous involvement of the physician, nurse, inhalation therapist and physical therapist.

In spite of the high (85%) percentage of hospitals having in-service respiratory care training, 95% of those surveyed reported that they felt an on-going respiratory care education program is desirable. This desire was supported by the fact that 71% of the hospital administrators stated that they would financially support attendance of their personnel at a respiratory care seminar or school.

Intensive Care

Of the 78 institutions responding, only one has a separate Respiratory Intensive Care Unit (RICU). This is to be compared with 55 (70%) of the hospitals which have a coronary care unit. In this 5-bed RICU, there is a physician in charge and 12 assigned nurses.

Of those institutions not having an RICU, intensive respiratory care is provided in general intensive care units which average ten beds and a staff of 13 nurses, eight of whom are reported to be specifically trained in respiratory care. According to those hospitals which kept such records, two patients per week per ICU were treated for respiratory failure.

Questions were posed concerning specific respiratory intensive care techniques. The majority (73%) now use low pressure cuffs on the endotracheal-tracheostomy tubes and 73% use specific physiologic criteria to estimate the appropriate

time of extubation.[4] Ninety-four percent stated that they had facilities to administer continuous positive pressure breathing (CPPB) available while 64% reported that they monitored central venous pressure on patients being ventilated with CPPB. However, only 10% of the hospitals use the new flow-directed balloon catheters[5] to assess pulmonary artery or left atrial (wedge) pressure.

Inhalation Therapy

Ninety-four percent of the hospitals have an inhalation therapy service and a physician is in charge of this service in 85% of them. He may be an anesthesiologist (47%), internist (24%), general practitioner (4%), or other (8%). In these services, there are 14 people who administer inhalation therapy, of whom 8% are registered with the American Registry of Inhalation Therapy (ARIT). Ninety percent have inhalation therapy services available 24 hours a day. The average number of IPPB treatments given per week is 563 with a range of 15 to 1050.

The average number of pressure-cycled ventilators per hospital is 17; volume-cycled, three. Although 96% of the hospitals have piped-in oxygen, only 55% have piped-in compressed air. This deficiency is offset by the fact that 68% stated that they use venturimasks to control the concentration of inspired oxygen.

Physical Therapy

Eighty-eight percent of the hospitals reported a physical therapy service; 83% provide physical therapy procedures appropriate for acute and chronic respiratory care. This is especially meaningful because only 7% have physical therapists alone who do postural drainage; apparently nurses and inhalation therapists perform the majority of this service in the remaining hospitals. This may be explained by the fact that the average number of physical therapists per hospital is only three.

Hospital Visitations

Hospital "A" is a 306-bed private hospital with 16,170 annual admissions. The director of the Pulmonary Disease-Respiratory Care Service is an internist in private practice with subspecialty training in pulmonary diseases. The pulmonary function laboratory is equipped to do blood gas analyses, spirometry, nitrogen washout, and body plethysmography. This hospital has an active cardiac catheterization laboratory and facilities to perform fiberoptic bronchoscopy. An active inhalation therapy service is supervised by the internist. This service performs approximately 400 IPPB treatments per week by 13 therapists, one of whom is registered. Intensive respiratory care is provided in a general ICU which has no physician in charge, but which has a nurse with primary responsibility for respiratory care. The hospital does not have outpatient facilities for respiratory patients.

Hospital "B" is an 811-bed county and private hospital with 27,877 annual admissions. There is no physician who has direct authority over respiratory care-pulmonary disease. An internist and internist-allergist in private practice see most of these patients on a consultation basis. The pulmonary function laboratory, inhalation therapy department, and cardiac catheterization laboratory are under the supervision of an inhalation therapist (ARIT). His organization includes an extensive inhalation therapy training program at a local university and junior college. A cardiologist is the medical director of the inhalation therapy department. There is no physician in charge of intensive care or respiratory care education. This hospital also does not have an outpatient clinic.

Hospital "C" is a 306-bed private hospital with 17,566 annual admissions. The Respiratory Care Service is structured as a separate entity and consists of inhalation therapy, intensive care, pulmonary function, and outpatient facilities. The service has departmental status within the hospital and accounts for an extensive portion of the hospital's income. The service is made up of a full-time physician-director, a nurse who is full time on the service, two pulmonary function technicians and 26 inhalation therapy technicians, two of whom are registered. The physician-director also has primary responsibility for respiratory care education within the hospital. Because of the lack of physical therapists, the members of the Respiratory Care Service provide postural drainage and IPPB treatments simultaneously when indicated by the patient's condition or when ordered by the patient's physician.

Hospital "D" is a 646-bed private hospital with 21,829 annual admissions. This hospital has an active Pulmonary Disease-Respiratory Care Service under the direction of an internist-pulmonary disease specialist. The service consists of three pulmonary disease specialists who are on the full-time staff of the hospital. They have an extensive training program consisting of two residents, one intern and three full-time pulmonary function laboratories each with sophisticated equipment for determination of spirometry, closing volumes, diffusion, pulmonary capillary blood

flow, cardiac output, and lung mechanics determination. The service sees an average of six to eight inpatients and three to five outpatients per day. Bedside fiberoptic bronchoscopy is performed on two to three patients per day. The pulmonary service also has direction of the inhalation therapy service as well as the clinical blood gas laboratory. The pulmonary service does not run the intensive care unit; however, patients there with respiratory problems are seen on a consultation basis.

Hospital "E" is a private hospital with 506 beds with 18,235 annual admissions. The Pulmonary Disease-Respiratory Care Service is under the direction of a thoracic-cardiovascular surgeon. The service consists of the physician and a team of 24 inhalation therapists headed by a registered inhalation therapist. The service sees patients with respiratory problems in consultation and directs respirator management. The hospital is planning a respiratory care unit in its current building program. The pulmonary function laboratory has the capability of performing basic studies such as spirometry, lung volumes and arterial blood gases. There is no outpatient facility as such; however, outpatient services such as IPPB treatments and pulmonary function studies are provided.

Nursing Home Survey

Of the 50 nursing homes selected, 15 refused to return the survey form despite repeated mailings and in-person visits by volunteers from the local TB-RD association. The responses of those 35 (70%) which did reply were analyzed. The participating homes represented 13% of the 269 nursing homes in the state and 6,253 (24.5%) of the 25,586 nursing home beds. The mean number of beds is 179 and the mean bed occupancy is 81%.

There is a mean of 7% of the total nursing home patients having chronic lung disease and 3% have respiratory disease as their primary diagnosis. This is in comparison to 30% of the patients with the primary diagnosis of coronary artery disease, 39% with the diagnosis of cerebrovascular disease and 5% with cancer.

Of those patients who are admitted with the diagnosis of lung disease, 18% are reported to have asthma; 22%, chronic bronchitis; 82%, emphysema; and 11% tuberculosis. Two percent of the patients with the diagnosis of lung disease are said to be in cor pulmonale.

Professional Staff

Of the nursing homes responding, 20 (57%) have an attending or consulting physician. Of these physicians, eight are general practitioners; five internists; two surgeons; one allergist; one oncologist; and three unknown.

There is an average of 10% of the nursing home staff with an RN degree. The mean patient/RN ratio is 16 to 1. An average of 12% of the staff has LPN training with a patient/LPN ratio of 14 to 1.

The average patient/staff ratio is 1.66 patients to one staff member. Seventy-five percent of the nursing homes responding have a physical therapy department; 1% of the staff members are physical therapists. The ratio of patients to physical therapists is 24 to 1.

Eighteen percent of the nursing homes have an inhalation therapy department. When inhalation therapists are present on the staff (four homes), the patient/therapist ratio is 72 to 1. A total of 18 (51%) of the nursing homes has respirators available and 1% of the patients are receiving oxygen therapy and 1% IPPB treatments. Three percent of the total patients are receiving postural drainage or some form of respiratory physical therapy.

Eighty-eight percent of the nursing homes reported that they had a person on their staff experienced in respiratory care; 85% stated that they felt sufficiently equipped and staffed to handle their respiratory care problems. However, 85% also stated that they would send their personnel to a respiratory care school or seminar.

Three percent stated they had some diagnostic pulmonary function equipment but none had facilities for the performance of arterial blood gases. Nine percent of the nursing homes stated that they had a chest x-ray unit.

Comments and Conclusions

In conducting a survey, several important factors bear heavily on the accuracy of the data obtained. The first concerns the method of survey. This can be illustrated by the fact that the return by mail of the nursing home questionnaires was 70% while the return of hospital questionnaires with information taken by the volunteers was 97%. Other factors to be considered are the enthusiasm, perseverance and skill of the interviewer and the patience, enthusiasm and knowledge of the interviewee. Little information is available about these factors; however, perusal of the questionnaire forms gives one the impression that there was considerable variation in the accuracy of the responses. Another factor heavily

involved is that of the motive of the interviewee. Pride in job or institution may lead to falsely high or low answers for questions such as number of procedures accomplished or the presence of esoteric equipment.

Visitation of selected hospitals—while giving the visitor the flavor of the particular program—can scarcely give quantitative or statistically-significant data unless performed in an identical manner in a significant number of institutions. This, then, is fraught with all the problems of inspection as a data-collecting technique.

From the mortality data, it is obvious that respiratory diseases are a significant and increasing health problem in Florida. Mortality data, however, are known for their inaccuracy, especially in the case of chronic obstructive lung diseases, in view of the fact that death certificates may be signed out as pneumonia, influenza, or heart failure. There are also a significant number of non-respiratory entities in which respiratory failure may be the main cause of death. The rapid rise of COPD in the last ten years is probably related to better recognition of the diagnosis as well as to the steady rise in smoking. The importance of chronic respiratory disease as a cause of death in the state is reflected by the fact that it ranks 9th overall in cause of death nationally and 6th in Florida. This is probably related to migration of elderly respiratory disease patients from other areas of the country.

In surveying the larger hospitals, it becomes apparent that 22 (28%) had little information on the occupancy rate of respiratory disease; however, discharge records provided a better basis of comparision using the discharge codes from medical records. These figures suggest that 5% of all discharges are patients with COPD.

The emphasis placed on respiratory problems by the hospitals is suggested by the fact that 53% stated that they had an organized pulmonary disease-respiratory care program. There was evidence from both the answers to the questionnaires as well as from the hospital visits that the efficiency and excellence of these programs was directly related to the presence of an enthusiastic, trained physician whether anesthesiologist, internist or other. Those hospitals which had these trained individuals generally had more facilities and services available as well as generally higher utilization thereof. This can be seen especially in pulmonary function testing. When a physician trained in their use was present, these laboratories were well utilized. The overall lack of such physicians is reflected in the fact that only 24% of the hospitals could do what most chest physicians consider a reasonably complete evaluation, e.g., spirometry, lung volume determination, and diffusing capacity determination. Of some surprise was the discrepancy between the number of technicians available to perform these studies and the number of studies performed, i.e., an average of four technicians to perform as few as 10 spirometries, 5 lung volumes, 9 diffusing capacities, and 54 blood gas determinations per week.

The other esoteric diagnostic facilities were impressive in the frequency of their presence, i.e., 69% have pulmonary angiography and 82% have radioisotope lung scanning. A somewhat disappointing finding was the fact that only 65% of the hospitals performed a routine admission chest x-ray which is believed by many to pick up more abnormalities, i.e., unsuspected tuberculosis, than the mobile units.

An impressive finding was that an average of one patient per day with acute respiratory failure was treated in the emergency rooms of these hospitals. This suggests a relatively high frequency which may be higher still considering that 51 (65%) of the 78 hospitals answering had no data on the frequency of respiratory problems seen in the emergency room. The rising usage of these health care facilities also suggests that this number, although significant, may be falsely low.

Although 85% of the hospitals surveyed stated that they had in-service training programs and someone to conduct them, only 50% of these programs were for physicians. With the advances in the diagnosis and treatment of respiratory diseases in the last ten years, it appears that the physician is obtaining the least amount of this on-going hospital-based training. In spite of the number of hospitals (85%) having an in-service program in respiratory care, an impressive 95% of the hospitals stated that they felt an on-going program of respiratory education is desirable in Florida. This finding is encouraging in view of the fact that 71% of the hospital administrators expressed a willingness to support attendance of their personnel at a respiratory care educational program.

It is obvious from the survey that the majority of intensive respiratory care is being performed in general intensive care units. In comparison to one hospital in this group with a specialized respiratory intensive care unit are the 55 which have

coronary care units (70%). This may reflect the greater need for coronary care as seen from mortality statistics but, also, may speak for the public relations appeal of heart disease.

A striking finding from the survey is the number of intermittent positive pressure breathing treatments being given per week in some hospitals, especially to outpatients. Since the efficacy of these treatments is controversial at best, one might suggest either a monetary motive or lack of physician direction behind the frequency of availability and the usage of these treatments. It is not surprising, therefore, that the income to many hospitals from inhalation therapy services rivals that from x-ray or laboratory services.

The relative paucity of chest physical therapy facilities is well illustrated by the finding that, although 83% of the hospitals stated that they provide chest physical therapy, only 7% of the hospitals had physical therapists alone to perform these procedures.

Summary

A study was conducted to assess the importance of respiratory disease in Florida and to obtain data on health care resources available to meet the problem. The study was performed by obtaining available mortality statistics from the Florida Division of Health and performing a survey with computer analysis of 78 hospitals with a bed capacity greater than 150 and of 35 nursing homes with a capacity greater than 125 beds. Results suggest that chronic obstructive respiratory disease is the 6th leading and fastest-rising cause of death in the state. Analysis of the hospital survey suggests that, while the majority of the hospitals have the equipment necessary to provide respiratory care, what is needed most are physician-directors to efficiently utilize the available equipment as well as the provision of multiple-level education programs on the advancements and techniques available. The survey of nursing homes reveals a low utilization of these health care facilities in the treatment of respiratory disease and a concomitant paucity of specialized personnel and equipment to do so.

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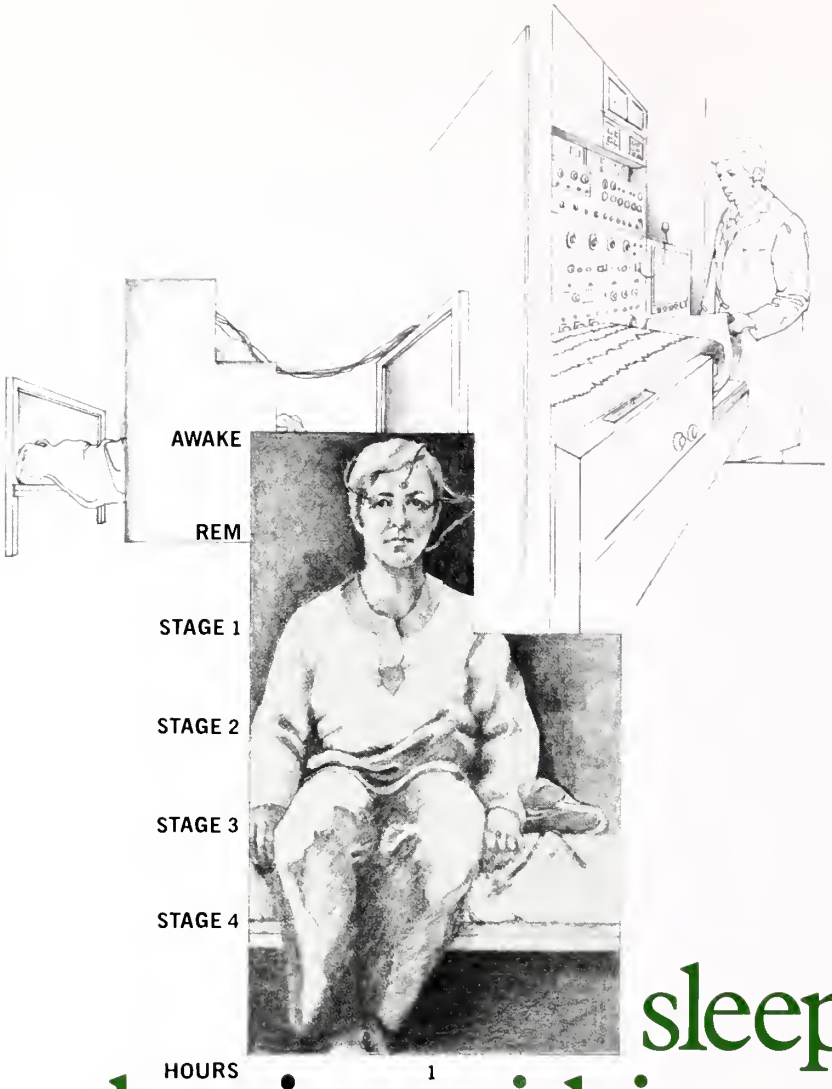

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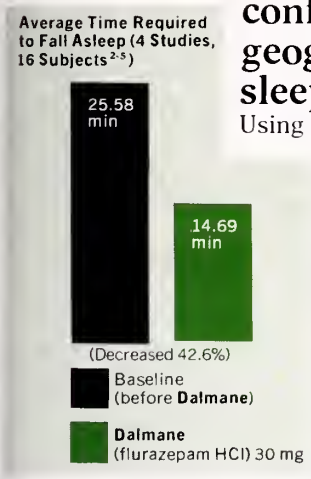

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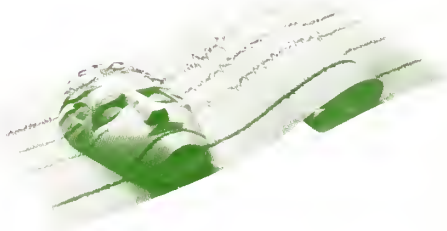

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

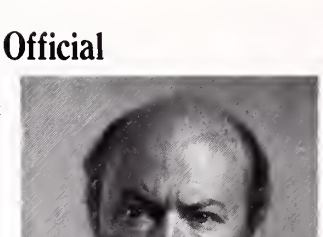
What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

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should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

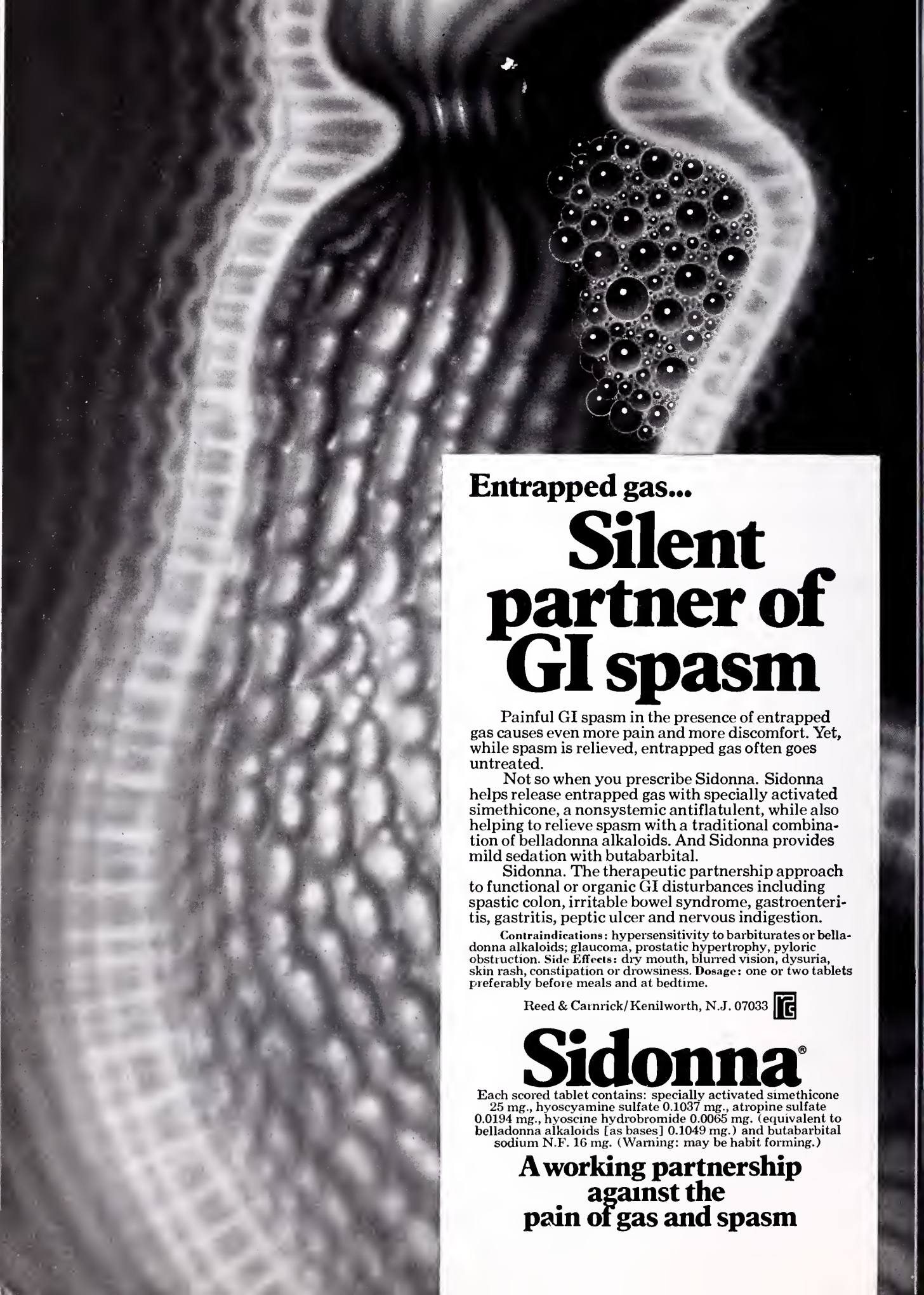
Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



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Special Articles

Senior Medical Consultants

LEON SCHIFF, M.D.

"One of the sad, senseless errors of the modern era, in this country particularly, is the compulsory retirement of capable teachers on the arbitrary basis of age, and age alone. Chronology replaces the values of maturity, judgment and experience." (Editorial, New York State Journal of Medicine, February, 1974).

A new nonprofit organization has been formed, now supported by grants and donations only, known as the Senior Medical Consultants (SMC) and is meeting with much success in New Jersey, New York, California and Arizona. Detlev W. Bronk, Ph.D., president emeritus of Rockefeller University, is now president of this group which has an outstanding board of trustees and an advisory council consisting of eminent physicians.

The teaching programs take the form of lectures, ward rounds, review of autopsies, presentations of new techniques, both clinical and laboratory; conferences, clinical sessions, assistance with planning for the future, and even promotion of research efforts in the institution. Such educational activities can only help to benefit the staff and the patients directly, and improve patient care generally.

There exists a substantial number of highly qualified, but frequently under-utilized physicians who have demonstrated their ability as teachers of medicine. These men and women, recently retired or soon-to-be-retired members of medical school faculties, are highly qualified and motivated, and desirous of continuing their professional activity with time available for teaching sessions. It was the vision of one of these physicians, Dr. Moldaver, clinical professor of neurology at the Columbia University College of Physicians and Surgeons, which led to the establishment of the Senior Medical Consultants project.

In July, 1970, the Bureau of Health Manpower of the National Institutes of Health agreed to fund this program for one year, after which the National Institutes of Health funded the second phase of the project, in which the services of the physician–teachers were offered to participating hospitals with a token $100 honorarium for each clinical instruction session. In September, 1972, with the termination of the contract with the National Institutes of Health, Senior Medical Consultants was incorporated as a nonprofit organization with tax exemption status, so that funding might be obtained from private sources. All donations are used to provide for clinical sessions at the participating hospitals and for administrative expenses. Some hospitals have been contributing financial help.

During the first nine months of 1973, Senior Medical Consultants' physician-teachers have visited more than 20 hospitals, conducted 243 clinical teaching sessions in all of the subspecialties of internal medicine, general surgery, obstetrics and gynecology, neurology, psychiatry, orthopedics, ophthalmology, forensic medicine, pathology, rehabilitation and genetics.

These teachers are not to supplant private consultants. They are not involved in any peer function. They participate in clinical conferences and ward rounds and, in general, bring teaching center expertise to outlying institutions. The outstanding feature of this innovative teaching program is that it delivers the expertise of medical schools directly to the practicing physician in relation to the patients who are most relevant to him —his own.

The organization is looking for additional qualified physician-teachers in all specialties to join the program, and for institutions that can utilize such talent. In Florida, Leon Schiff, M.D., Clinical Professor of Medicine at the University of Miami is starting a Senior Medical Consultants project in southern Florida.

Inquiries and suggestions may be sent to: Leon Schiff, M.D., Department of Medicine, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami, Florida 33152.

Avoiding Referral Mistakes A Function of Good Manners

Eric F. Geiger, M.D.

Abstract: Awareness of where one stands in the referral process; the maintenance of good communications and adequate records; and the prompt use of ordinary courtesy: these are the tools used by any physician who consistently avoids making referral errors. This is an outline of the inter-physician relationship and responsibilities involved in the sharing of any patient's care by more than one physician.

Medical care is seldom limited to the traditional total care of a patient by a single doctor. Instead, each person or family usually has a primary physician. He may be a general practitioner, internist, pediatrician or obstetrician. When an illness occurs that requires the services of another physician, a referral is made. It may be for evaluation and recommendations for a particular ailment (a consultation), or for transfer of the patient for management of the current illness. When referrals occur, possibilities arise for misunderstanding due to lack of good communications or incomplete work-up. These factors often result in less than excellent care for the patient and less than optimal interphysician relationships.

At what point in care and to whom a patient is referred depend upon many variables. Those related to the doctor include his training, emotional and professional maturity, and economic situation. Those related to the patient include the disease process involved, his financial status, and his degree of sophistication in medical matters.

As this indicates, the dynamics of the referral process are complex. The ethics of referral are based entirely on thoughtful courtesy and good medical care and are not complicated.

It is essential that any physician involved in patient referral clearly understands his own role in order to communicate well with the patient and with his colleagues. Otherwise, he may unknowingly obstruct optimal care or offend the physician sending a patient to him or receiving a patient from him. This may reach the point that his colleagues no longer voluntarily refer patients to him or see patients for him.

This paper describes the relationships that develop between doctors as a result of the referral process. It is designed for beginning practitioners but also may be a gentle reminder to seasoned physicians. It is based on the premise that the delivery of medical care by more than one physician creates a group of assumed responsibilities.

Classification of Physicians

Physicians involved in patient referral can be classified as the primary physician and as the primary or secondary consultant. These roles will be different with different patients and, indeed, may change during the treatment of a single patient. The primary consultant is usually a specialist to whom a patient is referred because the nature of the illness falls in the realm of his expertise. A secondary consultant is a specialist to whom the primary consultant sends the patient. This referral is often made for completeness of diagnosis but may occur because the patient's chief problem lies within the special field of the secondary consultant. The secondary consultant, if he assumes the major care of the patient, then becomes the primary consultant. Frequently, the patient will consult a specialist without a referral. Therefore, it is important that the doctor knows whether the patient was referred or whether he came of his own volition. If the patient was not referred, the doctor should find out from the patient whether he has a primary physician to whom he wants a report sent.

Basic Interphysician Responsibilities

The minimum responsibilities arising between two physicians when one refers a patient to the

other are:

1. Request for referral, furnished by the primary physician: This should clearly state whether the request is for a single consultation only (with evaluation and recommendations) or for transfer of care. This is best written, but more often than not is stated by the patient.

2. Acknowledgment of the referral: This should be done even though the patient may fail to keep his appointment.

3. Furnishing accurate complete patient data: These data are transmitted at the original referral. The primary consultant then maintains communications at regular intervals with follow-up reports to the primary physician.

4. Return of the patient to his primary physician: This occurs after resolution of the problem or after one visit if the referral was for consultation only.

Establishing confidence and rapport between the physician instituting and the one receiving the referral make mandatory the prompt acknowledgment of the referral and the final return of the patient with a summary of findings and appropriate recommendations for management. For the primary consultant to neglect these steps will understandably soon prompt the referring physician to look elsewhere for specialty care for his patients. The transmission of accurate patient data at the initial consultation has importance similar to the acknowledgment and final return of the patient. But it also is basic to the accurate diagnosis and treatment and involves medicolegal implications as well as the potential of added economic burden to the patient. This is especially true if expensive diagnostic tests are unnecessarily repeated because of the lack of an accompanying report of the results of tests that have already been performed by a referring physician.

Common Pitfalls in Referrals

Errors in proper management of a referral may arise from action of the referring physician, the consultant, or the patient. Problems are created by the primary physician if he: (1) fails to furnish a clear statement of the type of referral requested or, (2) if he does not send adequate patient data. The most common pitfalls affecting the primary consultant seem to be: (1) failure to determine what type of service is requested and failure to acknowledge the referral; (2) sending inadequate or late reports to the primary physician; (3) failure to return the patient to the primary physician after resolution of the problem prompting referral; (4) implication (consciously or unconsciously) that the previous care was poor, and (5) failure to notify the primary physician when a secondary consultant is sought. Also the primary consultant may fail to inform any secondary consultant involved of the identity of the primary physician. Actually, the securing of any secondary consultation should be done either by the primary physician or with his knowledge and approval in conjunction with the wishes of the patient. The patient may create a communication gap if he fails to inform the consultant that he was referred.

Ways to Improve Referral Relations

Most errors in referral relationships are unintentional (late reports, records misplaced, forgetfulness, etc.) and usually are thoughtless omissions. Therefore, it is essential that any physician striving to give optimal care to his patients and to maintain a positive relationship with his referring colleagues should develop habits of communications that prevent these errors. He should begin with ascertaining whether or not each new patient is physician-referred or self-referred. The patient should know whether it is a consultation only or transfer for management of a problem. Next, the consultant should speak directly to the referring physician after seeing the patient. Personal conversation cements good relations. This also supplements information brought by the patient and prevents repetition of diagnostic tests. In addition, it affirms that there has been no misinformation or manipulation by the patient.

A major bulwark against problems is an initial letter acknowledging the referral, reporting the medical findings and outlining the management plans. If this is dictated on the day of the first examination and reaches the referring physician two days after the phone call, he is assured of diligence in caring for his patient. Short notes on follow-up visits keep him actively informed and involved. The final step can be a letter summarizing the management of the patient's problem and returning the patient to his care. This acknowledges the primary physician's role and conveys the implication that future patients will be cared for in a similar manner.

The avoidance of remarks, gestures and grimaces that are critical of previous medical care or that could be construed as critical is extremely

important. This is imperative not only in the relationships present in the current problem but is a prominent factor in the maintenance of patient confidence. Numerous lawsuits have originated when the patient became convinced that one doctor thought another doctor's care was faulty. The critical physician (whether or not criticism was justified) may temporarily win the patient's confidence, but he often causes the patient's loss of confidence in his previous physician. Also, two other important consequences are likely: the loss of any more referrals from the physician to the critical physician, and a subpoena for the critical doctor to testify against his colleague in a malpractice action.

A frequent source of error and unhappiness is failure by the primary consultant to involve the referring physician in the future referral process when more than one specialist may be involved. Automatic cross-referral in a group may exclude one or more specialists who may be preferred by the referring physician or it may involve a consultant in whom the primary physician has no confidence. A discussion with the patient and the referring physician prior to further referral to a secondary consultant is the only way to avoid this type of error. Such failure to involve the primary physician may create and foster the image of such a group as being an impersonal machine that takes in patients, ships them around within the group for any needed attention, and then spews them out, perhaps not even back to the referring physician. This image will make it likely that the primary physician will cease to refer patients to that particular consultant. And, in addition, he will be less likely to use the services of any of the other partners within that multispecialty group.

In-hospital consultations and referrals are notorious for the poor manners and lack of consideration so many primary (attending) physicians have for their colleagues who are consulted. By far the most frequent abuse is the failure to write a concise consultation request giving the pertinent data and services requested. The surprising fact is that the consultant almost always finds the necessary information and gets his job done. But too often this is only after digging through incomplete charts, often with no history and physical yet recorded, after questioning several nurses, or perhaps only after cautiously extracting from the patient just exactly why his or her doctor wanted the consultation performed!

Conclusion

A check list against referral pitfalls begins with the act of knowing (with each new patient) if a referral is involved and if so what type. The primary physician, initiating the referral request, should be specific in what service is requested, whether consultation only or transfer of patient. He should send adequate data and be sure the patient knows what to expect of the consultant. The primary consultant examines the patient, acknowledges the referral, and confirms the data he has received. This is best done by a phone call to the primary physician. He next sends a detailed written report of his findings and recommendations to the primary physician.

If the patient needs a secondary consultant, the primary physician and the patient should be involved in selecting him. The secondary consultant should be aware of the identity of the primary physician so he can properly report his findings.

In his dealing with the referred patient, the consultant should avoid any suggestion of criticism of previous medical care. Progress reports should be sent at appropriate intervals to the primary physician. At the conclusion of the illness or condition a letter should accompany the patient as he is returned to the care of his primary physician. This letter summarizes the treatment and includes prognosis and any recommendations for further treatment.

In conclusion, the proper management of any referral requires that in dealing with patients and fellow physicians one needs only to practice good medicine, maintain good communications, and use good manners.

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A Report on Physician Distribution in Florida

Robert P. Lawton

Abstract: On a statewide basis, the ratio of physicians to population in Florida is rising rapidly and, according to the criteria proposed in this report, will match the state's overall needs before the end of this decade, despite the great rate of population growth. Current shortages exist in primary care, particularly in rural areas, and in psychiatry, obstetrics/gynecology and rehabilitative medicine. The report proposes flexible baseline ratios as an aid to planning future physician supply and distribution.

The physician is the focal member of the health team. Fundamentally, any determination of health manpower needs and plans to meet those requirements must pay particular heed to the supply and distribution of physicians. There are beneficial extensions of the physician's services through improved organization and the advent of new types of health professionals but the physician is still quarterback of both the community medical team and the medical center team—in Florida as in the rest of the United States.

At the request of the Community Hospital Education Council of Florida a study was made of the distribution of physicians in Florida. The report of the study was made in June, 1973, and this article is essentially a synopsis of that report.

The purpose of the study was to assist the Council in its function of helping to provide a continuing supply of highly trained physicians, in the appropriate specialties, in the communities where they are needed. This was done by conducting an accurate inventory, by specialty, of physicians in active practice in Florida and identifying gaps in the supply and distribution of physicians.

The major findings of this study are as follows:

Numbers of Physicians

In March, 1972, Florida had a lesser number of physicians, 141 per 100,000 population,[1] than the average in the United States, which was estimated to be 159.[2] The rate of physician growth, however, is outrunning even the extraordinary gain in population and in early 1973, the Florida ratio had grown to 147 per 100,000 people.[1] These figures include doctors of medicine and osteopathy, federal and state physicians and those in administrative and teaching positions but do not include those physicians who report they are no longer active.

Even though the state has a growing number of physicians in general, in terms of the ratios recommended by this study Florida is significantly short of primary care physicians, including pediatricians. It is also particularly short of psychiatrists. There is a lesser shortage in obstetrics/gynecology and physical medicine. The state, as a whole, is adequately supplied with physicians in most of the other major specialties at this point in time.

Distribution

There are severe problems of distribution of physicians. The concentration ranges from 227 physicians per 100,000 persons in Dade County to no physicians who are residents in Lafayette, Liberty and Gilchrist counties.* There are reported to be three or less physicians in nine other counties. The concentrations of physicians in certain of the coastal counties of Florida make them relatively rich in physicians' services. On the other hand, Florida's great geographic size, its long distances to marketing centers for health care and other services, and its sparsely populated areas in the Big Bend and down the central core put many Floridians out of convenient reach of physicians' services at the primary level and, to a lesser extent, at the secondary level. This poor distribution of physicians is a major problem in Florida and should receive even more stimulus for improvement than the matter of total physician supply.

Immigration

The number of physicians licensed and reported as active underwent a net increase of 749 be-

Mr. Lawton is Associate Director for Manpower Development and Education, Florida Regional Medical Program.

This is a report of a study supported by funds provided under Title IX of the Public Health Service Act. The opinions and recommendations herein are those of the author and do not necessarily reflect the view of the U.S. Public Health Service or the Regional Medical Programs Service.

*The Department of Community Health and Family Medicine at the University of Florida College of Medicine reports that it makes primary physician services available to 90% of the people of Lafayette County through its Lafayette County Health Center. This Department also operates a program in Gilchrist County, making available the services of physicians' assistants under the supervision of physicians on the faculty of the Department.

tween March, 1972, and February, 1973, according to the reports of the Florida Department of Professional and Occupational Regulation.[1] This is an extraordinary growth for one year. Most of the growth comes from physicians who have migrated to Florida from other states. Further, in February, 1973, the DPOR reported that there were 6,781 doctors of medicine and over 1700 osteopaths who held Florida licenses but who had not yet established a practice in the state.

It is observed that the growing inmigration of physicians is having a marked and immediate effect on the availability of medical services in Florida. It not only will keep the supply of physicians even with the growth in population but will continue to raise the ratio to population.

Fundamentally, the numbers of doctors of medicine in this study were those listed by the Central Automated Physician Information System, a program of Fisher-Stevens, Inc., based on data from the American Medical Association's physician master file. These are the 9,316 physicians, both members and non-members of the AMA, who were considered to be professionally active in Florida on February 16, 1973. This total is about 1,000 less than those reported by the Florida Department of Professional and Occupational Regulation as licensed and resident in Florida at that time. This is consistent with the general opinion that there are several hundred doctors of medicine in Florida who are licensed and reported "active" but whose practice essentially has been terminated. Also included in the inventory were 603 doctors of osteopathy[1] for a total inventory of active physicians of 9,919. These active practitioners were then segregated by type of practice and by county. In type of practice, a category was created of physicians in "primary care," including those physicians who were in general practice, family practice, internal medicine and its subspecialties, pediatrics and the osteopaths. This inventory is included in this report as Table I.

In addition, this inventory was extensively cross-referenced with directories and through personal communication to adjust for those physicians who were engaged in teaching, were in training, were in public health or were not otherwise actively engaged in active clinical medicine. These were classified as "not in practice."* Another inventory refinement eliminated anesthesiologists, pathologists and radiologists since they differ from other clinical specialties because of their significant institutional relationships. These two adjustments reduced the number of physicians in the study to 8,289 for comparative analysis.

Attempts to determine the need for physicians in the various specialties in ratio to population accent the extreme lack of criteria for establishing these ratios. In addition, the ratios will be influenced by changes which are continuously taking place in the system of delivering health services. Knowles has cited scores of these variables.[3] In fact, they are so numerous and complex that they nearly defy their use as a basis for determining ratios and, as Knowles states, most may be altered at a moment's notice.*

On two occasions, in 1961 and 1967, *Medical Economics* suggested some ratios[4] and Steinle recently proposed some estimated ratios, described as "working" figures, rather than needs.[5] In April, 1973, Korst matched the number of Wisconsin practitioners against the national ratios and suggested increases in certain specialties.[6] This study has drawn on these, other similar reports and the actual ratios of physicians to population which exist nationally in the United States, and proposes the Florida Baseline Physician Ratios. These ratios include adjustments for the unusual age distribution and the geographic characteristics of Florida. The ratios propose 151 active physicians, including 80 primary care physicians, per 100,000 population—twenty more than were in active practice in February 1973. The ratios are listed in Table II.

Admittedly not applicable to every area or population, it is believed that these ratios have considerable value as baseline or foundation ratios which will help physicians, health planners and others to understand and identify a shortage (or excess) of physicians' services. They form a starting point which can easily be modified, and should be, for the particular characteristics of a specific population.

A comparison of the number of physicians in Florida at the time of the study (February, 1973), and the number of physicians required by the latest reported population, discloses a shortage of 1,503 physicians overall, with a particularly acute deficit of 1,376 primary care physicians.

*After removing physicians in public health, administrative and teaching positions, and those physicians whose practice essentially has been terminated, the ratio of Florida physicians in truly active clinical practice was 131 per 100,000 population in February, 1973.

*By no means does this report deny the need for better organization of the delivery of health services. However it is not likely that sweeping changes will occur in the nation or in Florida in the immediate future. Meanwhile, Florida's population and number of physicians grow at a fantastic rate.

Table I.—Physicians (M.D.'S and D.O.'S) Practicing in Florida—by Specialty and by County

Population 1,000s	County	Primary Care	Anesthesiology	Dermatology	Neurology	Neurosurgery	OB/GYN	Ophthalmology	Orthopedics	Otolaryngology	Pathology	Physical Medicine	Psychiatry	Radiology	Surgery	Urology	Other Specialty	Unspecified	Not in Practice	Total In Practice 2/16/73	Total Licensed March, 1972	Total Licensed Feb., 1973	Pediatrics
111	Alachua	133	22	2	7	7	22	24	12	11	9	1	34	21	53	6	5	3	67	439	466	480	39
10	Baker	3											8		1			1		13	11	13	
77	Bay	25				1	5	2	2	2	2		4	3	7	2			3	58	64	62	4
15	Bradford	3						1											1	5	7	6	
234	Brevard	84	4	5		2	19	7	8	5	7		7	6	23	7	1	3	7	195	191	216	13
682	Broward	459	36	18	13	11	60	33	43	23	21	2	40	48	93	33	7	3	4	947	948	1,045	53
8	Calhoun	2									1									3	3	3	
31	Charlotte	18	1				1	2	1		1		1	3	4	2	1	1	2	38	32	39	1
22	Citrus	7					1								3				1	12	9	14	
35	Clay	24	2	1	1		1	1			2		1	2	3			1	1	40	62	59	2
43	Collier	37	2	1	1	1	4	3	2	1	2		2	3	9	2	1			71	71	77	4
27	Columbia	17					3		1		1			2	3	2	1		1	31	28	30	1
1,341	Dade	1,290	120	46	36	24	170	108	106	51	80	15	177	128	306	69	31	25	148	2,930	3,046	3,243	151
14	DeSoto	7											7		2					16	12	16	
6	Dixie	2																		2	1	1	
547	Duval	237	35	8	8	7	69	25	32	14	20		26	33	92	23	3	7	29	668	684	735	44
213	Escambia	67	6	5	3	4	19	12	11	11	8		8	10	27	7		5	9	212	231	243	14
5	Flagler	2													1			1		4	3	2	
7	Franklin	4																	1	5	5	5	
39	Gadsden	14							1				8		2		1			26	23	28	1
4	Gilchrist	0																		0	1	1	
4	Glades	2																		2	1	1	
10	Gulf	3																		3	4	3	
8	Hamilton	2																		2	3	2	
15	Hardee	8					1								1		1			11	12	12	
13	Hendry	7					1													8	6	7	
18	Hernando	5					1							2	3				1	12	9	11	
31	Highlands	20					1								4				1	26	31	31	1
509	Hillsborough	256	18	8	3	3	40	24	21	18	26	3	34	36	68	20	7	4	22	611	621	672	38
11	Holmes	1																		1	3	2	
38	Indian River	23	3	1			4	2	2	1	3		2	2	4	2			1	50	48	54	2
35	Jackson	8												2	2			1	1	14	17	19	1
9	Jefferson	4																		4	5	5	
3	Lafayette	0																		0	1	0	
72	Lake	36	2				3	2	4	1	2			3	8	2		2		65	58	64	2
120	Lee	60	4	3	1	1	8	5	4	3	3		4	5	14	5	1		2	123	119	137	8
109	Leon	53	1	3	2	2	10	5	5	5	2		12	5	16	6	5		4	136	126	141	8
13	Levy	2													4					6	5	6	
3	Liberty	0																		0	0	0	
13	Madison	3													1					4	10	9	
103	Manatee	38	5	2	1	1	6	6	3	3	3		2	6	13	3	0		1	93	94	98	5
73	Marion	38	2	1		1	6	2	3	2	2		2	2		2	1		3	67	62	66	6

(Continued on next page)

Population 1,000s	County	Primary Care	Anesthesiology	Dermatology	Neurology	Neurosurgery	OB GYN	Ophthalmology	Orthopedics	Otolaryngology	Pathology	Physical Medicine	Psychiatry	Radiology	Surgery	Urology	Other Specialty	Unspecified	Not in Practice	Total In Practice 2/16/73	Total Licensed March, 1972	Total Licensed Feb., 1973	Pediatrics
31	Martin	16	1				5	1	3	1	1			1	4	1				34	29	37	1
53	Monroe	23	3	1			4	1	5	2	1		2	2	6	2	1		1	54	84	79	3
22	Nassau	9													1				1	11	5	13	1
94	Okaloosa	27		1			3	2	1	3	2		6	3	3	2	3	2	2	60	71	69	3
12	Okeechobee	4													1					5	6	7	
390	Orange	234	21	7	5	6	39	24	38	11	21	2	27	26	78	20	6	9	8	582	595	626	33
29	Osceola	9													3		1			13	12	15	
375	Palm Beach	228	18	10	4	5	31	22	25	9	12	2	21	25	67	14	4		8	505	523	560	27
85	Pasco	34						1		1		1		1	3	2				43	40	49	
547	Pinellas	374	27	10	9	6	38	34	31	17	25	2	33	35	71	22	8	1	5	748	757	804	22
240	Polk	120	11	6	2	3	26	11	12	6	6		12	20	37	7	4	1	1	285	278	301	17
37	Putnam	8					1								5				1	15	16	17	
32	St. Johns	10					1	1		1	1			1	2	1		1	1	20	22	26	1
53	St. Lucie	14	1				2	3	2	2	1		3	3	8	1			1	41	37	40	1
40	Santa Rosa	9	1				4	2						2	2			2	3	25	27	29	1
130	Sarasota	99	10	5	2	3	12	13	12	3	6	1	10	7	21	8	2	2		216	206	219	14
95	Seminole	28	5	1	1		4	2	2	1	2		1	2	8	1	1	2		61	52	70	4
16	Sumter	2																		2	5	4	
16	Suwannee	4																		4	4	4	
14	Taylor	6					1							1	1		1			10	6	9	
8	Union	6											1		1			2		10	4	11	
180	Volusia	107	5	2	1	2	13	8	11	4	4		8	10	22	7	1	2	5	212	221	235	7
7	Wakulla	1																		1	1	1	
16	Walton	6																		6	7	7	
12	Washington	2													1					3	3	3	
	TOTAL	4,384	366	147	100	90	639	389	403	212	277	29	503	461	1,112	281	98	81	347	9,919	10,144	10,893	533

NOTE: Primary Care includes doctors of medicine in General Practice, Family Practice, Internal Medicine and its subspecialties, Pediatrics and doctors of osteopathy. For information, the number of Pediatricians is shown in the last column to the right. Surgery includes General Surgery and its subspecialties, Colon and Rectal Surgery, Plastic Surgery and Thoracic Surgery. Population figures are to the nearest thousand of estimated population on July 1, 1972, according to projections of the 1970 Census of Population by the Bureau of Economic and Business Research, University of Florida.

SOURCE: Specialty and county breakdowns and total in practice are doctors of medicine from the Central Automated Physician Information System, adjusted by local data, plus osteopaths. The distribution of osteopaths and the total numbers of physicians licensed are as reported by the Florida Department of Professional and Occupational Regulation.

TABLE II

RECOMMENDED NUMBER OF PHYSICIANS BY SPECIALTY PER 100,000 POPULATION FOR FLORIDA
FLORIDA BASELINE PHYSICIAN RATIOS (FBPR)

	RECOMMENDED NUMBER FBPR
PRIMARY CARE	80
DERMATOLOGY	2
NEUROLOGY	1
NEUROSURGERY	1
OB/GYN	10
OPHTHALMOLOGY	5
ORTHOPEDICS	5
OTOLARYNGOLOGY	3
PEDIATRICS (Include in Primary Care)	(10)
PHYSICAL MEDICINE	1
PSYCHIATRY	10
SURGERY	15
UROLOGY	3
SUB-TOTAL	136
ANESTHESIOLOGY, PATHOLOGY RADIOLOGY	15*
TOTAL	151

*This is not a recommended ratio for these three specialties. This number is the ratio in which they practiced in Florida in 1973 and is included to round out the total clinical practitioner group.

There was also a shortage of 217 psychiatrists, 81 obstetrician/gynecologists and 43 physicians specializing in rehabilitative medicine. Most other specialties were in adequate supply on a statewide basis. These comparisons of actual practitioners with required numbers are shown in Table III. Projecting the population to its estimated size of 9,400,000 in 1980[7] and comparing the number of physicians required by that population with those currently practicing in Florida is also portrayed on Table III. This forecasts a total need by 1980 of 4,495 additional physicians, of which 3,136 should be in the primary care category.

A parallel projection of the growth in number of physicians, including both those graduated from Florida training programs and those who are migrating to Florida from other states, indicates that the need for approximately 4,500 additional physicians will be met. A simple projection of the physician gain in the year ending in February, 1973, develops more than enough gain to keep pace with even this mammoth population growth. In a report by Dr. Kenneth E. Penrod, Vice Chancellor for Medical and Health Sciences in the Florida University System, released in November 1973, fulfillment of total physician needs in Florida in 1980 is confirmed.[8] The Penrod report projects the latest Florida licensure trends and adjusts for attrition among the present practitioners.

A factor which influences the need for physicians and other health services is the requirement of Florida's visitors for health care. Virtually no data is available on these needs. Studies should be initiated promptly to gather that data so that their needs can be calculated in terms of the required number of physicians—as well as other health professionals, hospital beds and other health facilities. This report suggests that visitors might require 408 more physicians, including 240 more in primary care. However, this need varies greatly from area to area and is best met by adjusting the Florida Baseline Physician Ratios for an area on the basis of hard data from new, local studies. The estimate of 408 may be extremely low.

TABLE III.—PHYSICIANS IN PRACTICE IN FLORIDA COMPARED TO THE NUMBER REQUIRED BY THE FLORIDA BASELINE PHYSICIAN RATIOS (FBPR) FOR A POPULATION OF 7,200,000 AND FLORIDA'S NEEDS BY 1980 (EST. POPULATION, 9,400,000)

				Florida's needs by 1980	
	Number in Practice*	Required Number FBPR	Excess or Deficit	Required # by FBPR	Excess or Deficit
PRIMARY CARE	4384	5760	—1376	7520	—3136
DERMATOLOGY	147	144	+ 3	188	— 41
NEUROLOGY	100	72	+ 28	94	+ 6
NEUROSURGERY	90	72	+ 18	94	— 4
OB GYN	639	720	— 81	940	— 301
OPHTHALMOLOGY	389	360	+ 29	470	— 81
ORTHOPEDICS	403	360	+ 43	470	— 67
OTOLARYNGOLOGY	212	216	— 4	282	— 70
PEDIATRICS (Included in Primary Care)	(533)	(720)	(— 187)	(940)	(— 407)
PHYSICAL MEDICINE	29	72	— 43	94	— 65
PSYCHIATRY	503	720	— 217	940	— 437
SURGERY	1112	1080	+ 32	1410	— 298
UROLOGY	281	216	+ 65	282	— 1
TOTAL	8289	9792	—1503	12784	—4495

*as of February 16, 1973

The projection of an adequate number of physicians for the state as a whole does not solve automatically the problems of improper distribution. Some successful answers have been demonstrated but most of the solutions are yet to be devised by the profession. It is hoped that the data base and the ratios in this report can be updated regularly to provide direction for continuous improvement in the supply and distribution of physicians, on the part of the state and communities, Florida's physicians, medical educators and health planners. Two developments are necessary to guarantee adequate physician services for Florida's population in 1980:

1. There must be a marked increase in the number of primary care physicians. These are the types of physicians which are particularly needed in the rural, under-doctored areas and among the populations of our largest cities. Increasing the numbers trained in the primary care field in Florida's postgraduate educational programs and attracting the primary care physicians among those who are contemplating migrating to Florida are important solutions to this problem.

2. There needs to be better distribution of Florida's physicians in the future. Special efforts should be made to induce physicians in primary care and in the specialties to initiate their practice in those geographic areas where they are needed. The under-doctored areas are often those which are not attractive to physicians and their families. Medicine is learning throughout the United States that physicians can have financially successful practices without being fully occupied. Therefore, the solution to the maldistribution problem is not a simple application of the law of supply and demand.

A study of the 8,500 doctors of medicine and osteopathy who hold current Florida licenses but have not moved to Florida has been developed by the Florida Regional Medical Program. It is hoped that it will gather the information necessary to help influence the physicians contemplating a move to Florida from other states to go where there is a geographic or specialty need.

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Editorials

FDA — Approved?

Growing is a concern among practicing physicians that the power of the Food and Drug Administration over their prescribing habits is proliferating while only those MD's in academic settings approve the trend. Following a Supreme Court decision last June, the FDA has gained unchallenged authority to regulate all aspects of drug manufacture, labeling and promotion as well as demonstrating an increasing impact on drug utilization. Responding to charges that in this country, new drug approval lags behind that of other nations, the FDA conceded that there has been a lag in cardiovascular and respiratory areas. Officials, however, differ with statements that numerous preparations, drugs of choice for conditions abroad, are simply unavailable here, or that four times as many useful and uniquely effective safe drugs have been introduced in Britain substantially earlier than in the United States.

In recent years, the FDA has removed from the market over 650 drugs plus almost 5,000 related identical or similar pharmaceutical products under different names as "ineffective." This has been accomplished under the FDA's Drug Efficacy Study with the assistance of the National Academy of Science National Research Council in an 18 month review of all drugs approved by the FDA between 1938 and 1962. The NASNCR panel rated drugs as "effective, probably effective, possibly effective or ineffective," and this was written into the rulings of efficacy. These regulations were then confirmed by the Supreme Court, stating that a "substantial evidence" requirement reflects the conclusion of Congress "that clinical impressions of practicing physicians and poorly controlled experiments do not constitute an adequate basis for establishing efficacy." While this decision has given the agency (FDA) great power and authority, at the same time it imposes a responsibility to get the world's best judgment before making decisions affecting the availability (and labeling) of pharmaceuticals.

Following protests, the FDA has withdrawn from several regulatory positions. One followed an FDA statement in the Federal Register that a doctor "file an investigational new drug plan before prescribing an approved drug for unapproved uses . . ." Immediately a barrage of letters from practicing physicians to date has dissuaded the FDA from putting out the final regulation. Another tactical withdrawal followed a proposed changing in labeling of oral hypoglycemics on opinions made by the University Group Diabetic Program. This inferred a higher mortality on such medication, and was challenged by an eminent group of 80 Massachusetts diabeticians who secured an injunction to stop the printing of the labels. Allegedly, now, with the lifting of the injunction, a changed label will be forthcoming, yet the significance of this action suggests that the FDA will not observe the practicing physicians' judgment on either safety or efficacy. One threat, that of professional liability, perhaps may be prompting physicians to observe approved labeling, although there has not been an adverse malpractice verdict solely on the grounds of prescribing outside the limits of a brochure. A third action indicating FDA's willingness to arbitrate was the postponed implementation of the prescription cough-allergy guidelines, such action being deferred until its panel could complete a review of nonprescription cough-cold-allergy products. A final example occurred last summer when, after receiving numerous complaints from practicing physicians objecting to the removal of poorly absorbable sulfonamides, the order to withdraw these drugs was rescinded.

On the other hand, until last year, the pharmaceutical industry has argued that the language of the law allowed physicians' clinical experience with drugs to satisfy the 1962 requirement for "substantial evidence" to determine effectiveness. The amended law, however, specifies that "substantial evidence must consist of adequate and well controlled investigations, including clinical usage by experts qualified from scientific training

and experience to evaluate the effectiveness of the drug involved." The FDA interpreted the law to exclude isolated case reports, random experience and reports lacking details that permit scientific evaluation in proving effectiveness. This was upheld last June by the Supreme Court. Whatever the intent of the releases from FDA, the agency's historical push toward absolute control over drug utilization appears to be continuing, abetted by pressure from both Congress and consumer groups to require physicians to prescribe the way the government thinks they should. Plans for new projects, such as an FDA compendium, ultimately leading to a federal drug formulary, are in the planning stage.

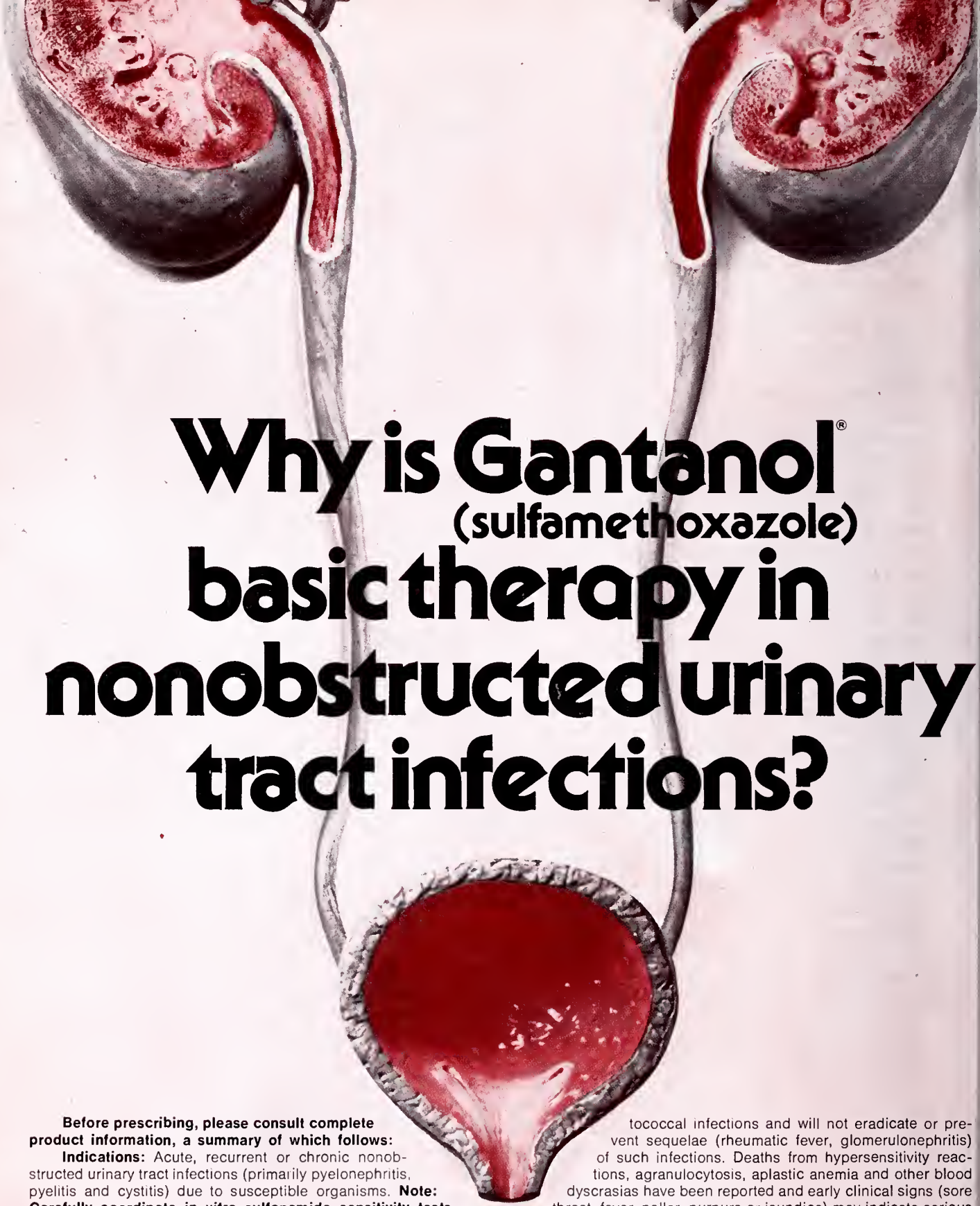
While many decisions that physicians most object to stem directly from the FDA enforcing the law, another major force has been the consumer group led by Ralph Nader who criticizes the FDA for not strictly enforcing the true intent of the law. Their battle cry is that there is an unacceptable danger to society to allow a doctor to use any drug he wants, for, "what doctors know about prescribing is from drug promotion detail men and a sketchy pharmacological education in medical school." Further, they say, "unless each doctor runs controlled studies, how can he know what the drug really does or what is its safety and efficacy." While most physicians believe that they should have the freedom to prescribe any drug on the market for any indication they might wish without a governmental agency directive to dictate this decision, yet, largely because of physicians' lack of interest in federal agencies, consumer advocates such as health research groups are becoming more powerful in controlling regulation of drug developments. A short time ago, the FDA was criticized by a lay organization for approving imipramine for bedwetting, beta-blockers for angina and depo-provera for contraception. This put the FDA in an untenable position, since the medical profession was not sufficiently informed or interested to mobilize support to the agency defending the physician's right to prescribe. On the other hand, patients are protected from "inappropriate trials of new therapies by federal law," say academician critics who fault practicing physicians, as well as those in university hospitals, for failing to pay heed to clinical trials. Perhaps future peer review committees will recognize that scientific data obtained from clinical trials are more reliable than the standards of a community where antiquated, uneffective and discredited therapies are in vogue.

Since a larger percentage of the population is getting better medical treatment than ever before due to better laboratory and clinical techniques for diagnosis and treatment of infectious diseases, plus increasing numbers of physicians, more people will expect some medication while the truth is that many patients seen in the office of primary care physicians need little, if any, medication. It is to this segment of the patient population that we must direct an educational program to curb over-prescribing. As a corollary, patient improvement oftimes is the result of the physician's kind and reassuring interest while the placebo-effect of the drug serves no physiological purpose.

All of the above notwithstanding, an honest appraisal of the dilemma must unroot overly enthusiastic, scientifically naive or biased clinical uses of drugs in human therapy. The basis of any therapeutic maneuver includes an evalution of both its efficacy and its toxicity and can be sought within the scientific literature. The choice of a treatment regimen for the individual patient must be based on the informed consent of the physician. This is what every student should be taught in medical school as to how to practice and for which physicians, from the day they graduate, conduct and participate in continuing education. Now, with a new commission promising more cooperation, the FDA may be moving to alter its image with physicians. One step toward more amicable relations has been the expanding use of outside advisory committees using practicing physicians, where they can demonstrate interest in an arena where they can express their opinions.

Tight and inflexible regulations governing not only the safety but also the efficacy of new drugs will promote therapeutic insularity or isolationism. This would even more likely occur should decisions be made by improperly advised civil servants. Rather should there not be an advisory committee of voluntary experts drawn from practicing physicians and medical school and pharmaceutical professors? The ideal system of drug control should be developed around the philosophy of education in the correct usage of drugs which are safe and efficacious.

C.M.C.



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Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

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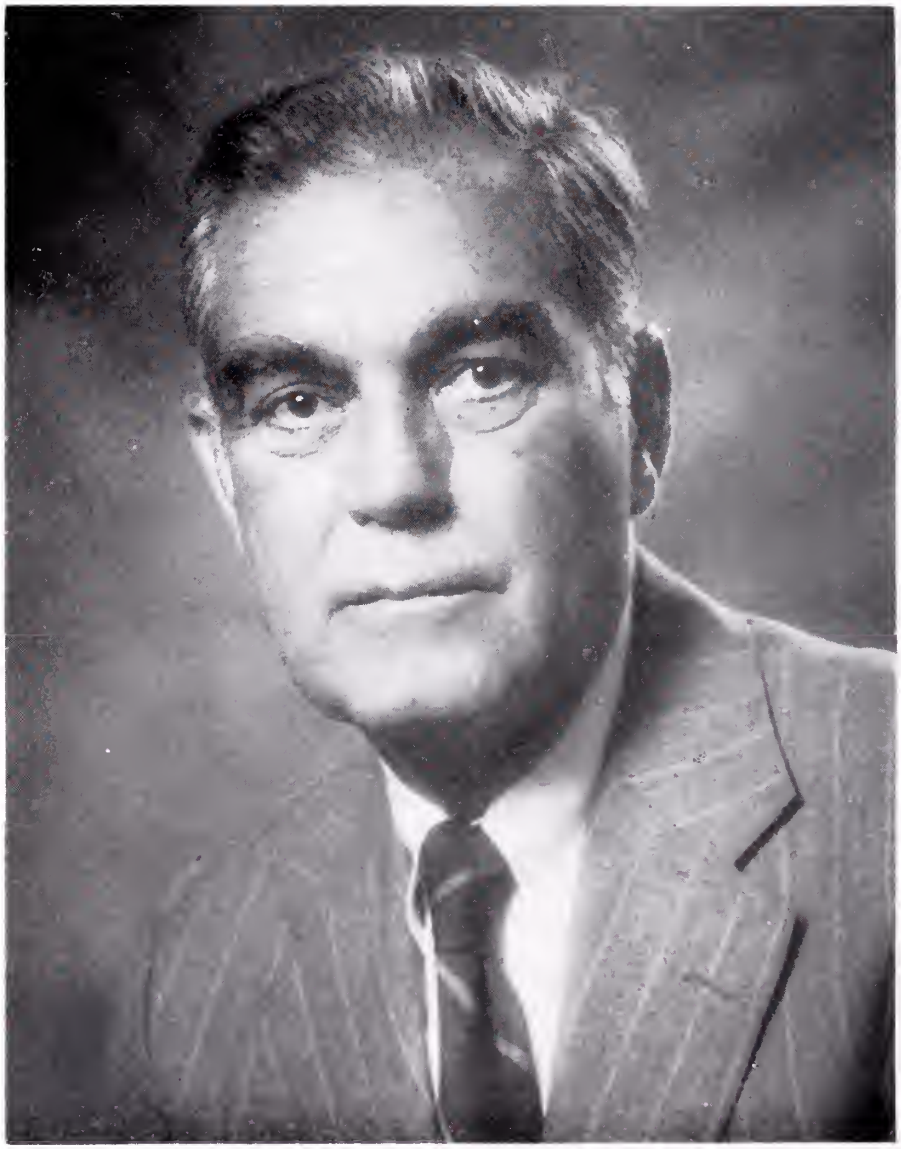


THAD MOSELEY, M.D.

Dr. Moseley, 98th President of Century-Old Association

Thad Moseley, M.D., of Jacksonville, a native of Mississippi, became the 98th President of the 100-year-old Florida Medical Association at the Annual Meeting last month in Hollywood. Transfer of leadership to him was accomplished in an atmosphere of harmony, but the gravity of the responsibilities could not be forgotten.

In the year ahead the necessary actions will undoubtedly be executed with gracious firmness, promptly, decisively, with a thoughtful balance of opinions. This is not surprising in the light of awareness that Dr. Moseley is a surgeon by special abilities and interest, and Presbyterian in his faith. Training and experience have impressed upon him the importance of anticipating problems, analyzing alternatives, and of being prepared to follow through.

When he became chairman of the Association's Committee on Scientific Work he found a traditional arrangement of the annual scientific program and sparse attendance at its presentation. Conferring with his colleagues and exchanging ideas, he concluded that scientific interests should be paramount and proceeded to bring about a voluntary coalition of various groups to cooperate in developing an annual scientific program. The offer he extended was one of cooperation and mutual assistance, profitable scientifically to physicians as individual practitioners and as members of a specialty group.

As editor of *The Journal* he recognized the physicians' pride in their county medical societies and the professional abilities and accomplishments of their members. Special issues resulted featuring their achievements. *The Journal* belonged to them, therefore, it should reflect their best scientific efforts.

To him, searching into the unfamiliar and unknown areas of medicine and surgery holds a special fascination. A former medical educator, he confesses to a love for teaching. In *The Journal*, however, he sought to differentiate between research in the basic sciences and that research which results in information immediately applicable to patient care. He questioned delaying the practical application of clinical findings until appearance of the conclusive report. His requests to the medical schools for concise statements of important research in progress—both basic and clinical—resulted in outstanding presentations.

Perhaps Dr. Sanford Mullen identified the key to Dr. Moseley's accomplishments in his address nominating him as President-Elect. Dr. Mullen represented the Duval County Medical Society which Dr. Moseley had served as president. "His roles of leadership," Dr. Mullen stated, "have been characterized by his willingness and ability to listen—with understanding—and by his ability to get people with diverse views to work together in a common cause."

"By his efforts he has achieved goals which seemed to be impossible . . . We know that Thad is primarily a doctor dedicated to the practice of medicine. His professional qualifications are of the highest order, but he is also a leader in organized medicine, recognized and admired by his colleagues."

Dr. Moseley had the ability to inspire others to follow even before he became active in a county medical society and the Florida Medical Association. Dr. Nelson Kraeft of Tallahassee who attended Vanderbilt University School of Medicine with him states: "I know first hand of his earliest accomplishments in medicine as well as his later and more recent work."

"My acquaintance with Thad Moseley began nearly 34 years ago when we both entered medical school in Nashville. He was an outstanding performer and leader throughout medical school. During the past 30 years his continued vigor and enthusiasm coupled with increasing maturity and experience have culminated in the type of leadership which our Association needs for guidance in the difficult days ahead."

Dr. Kraeft, one of several colleagues who rose at the Annual Meeting to second the nomination of Dr. Moseley for President-Elect, recalls in retrospect that "the few words I said about Thad now seem too brief and inadequate."

Dr. Moseley enjoys his work with civic groups, the Jacksonville educational program for interns and residents and the relaxation of sailing and gardening. His wife, Linda, was a student at Vanderbilt University where they met and married following his service as a captain in the Army Medical Corp during World War II. Following completion of a surgical residency at Vanderbilt University Hospital they moved to Jacksonville in 1950. The family is made complete by Thad, William and daughter Stacy.

The 100th FMA Annual Meeting

The Centennial meeting of the Florida Medical Association with the largest attendance ever in its history, and undoubtedly the best program, came to an end Sunday, May 12 following the House of Delegates' decision on Vernon B. Astler, Palm Beach County, for President-Elect. The new Vice President is Irving Essrig from Hillsborough County, while Louis C. Murray from Orange County was elected Speaker of the House and Charles J. Kahn of Escambia County, Vice Speaker. James W. Walker from Duval County was re-elected Secretary-Treasurer and began serving his fifth year in that office.

Wednesday afternoon, May 8th, Speaker Franklin Evans, opened the meeting by calling the first session of the House of Delegates to order, asking Jack Q. Cleveland to give the invocation. He accepted a motion to seat the delegates. The report of the Woman's Auxiliary was then sung by their president, Mary Ann Mathews, in perfect pitch, set to the music of popular songs from "Sound of Music." For this, she received a standing ovation. FMA past presidents were introduced and were given a warm ovation. Jere Annis was given a second ovation on the announcement that he had been named the nation's outstanding physician in his specialty by the American Society of Internal Medicine.

The tone that later determined the actions of the House of Delegates was set by Joe Von Thron in his president's address when he suggested to his audience that they *not participate* in PSRO negotiations. Thursday morning, most delegates were up at 8 a.m. for the annual Blue Shield meeting. This was followed by Reference Committee meetings which included: Health and Education; Public Policy; Finance and Administration; Legislation and Miscellaneous, and Medical Economics. The chairmen who guided these meetings were Richard M. Fleming; Andre S. Capi; DeWitt C. Daughtry; John A. Rush Jr., and John C. Fletcher respectively.

Thursday noon, at an awards luncheon of the Auxiliary, ribbons and prizes were given for the best works of art submitted by physicians and their families. At 5:30 p.m. Dr. William Masters spoke to a packed house of physicians and their wives, telling them that he had treated some 2,000 couples in a 20 year study of sexual dysfunction with an overall failure rate of around 20 per cent. He urged physicians to be alert to symptoms of these sexual disorders and consider questions to elicit such information in every routine history taking. Also that afternoon the Florida Physicians Association convened with James Cook, president, giving an executive committee report, recommending to FPA members that they not participate in PSRO. Friday saw many delegates and visitors strolling through the exhibits where there appeared innovations in communications, audiovisual tapes and players as well as scientific panels and pharmaceutical booths.

At the General Session on Friday morning, the Baldwin Lecture was given by the Honorable Otis R. Bowen, M.D., of Indiana, a general practitioner and the only physician governor in the 50 states. He stated that PSRO would be one of the most divisive programs ever created, pitting doctor against doctor; indeed prophetic, for on Sunday the House of Delegates divided itself on this issue. Friday at noon, the FMA Woman's Auxiliary joined FLAMPAC for their annual luncheon. Ed Haskell, FLAMPAC president, introduced Marilyn Van DerBur Atler, a former Miss America, who, in an inspiring address, kept her audience on the edge of their seats when she advised each one, no matter how old, to develop a goal. This alone was worth traveling across the state to hear.

That evening, the president's poolside reception was graced by Abel Seymour Baldwin, alias Sam Day, bearing a sign on his shirt front saying, "I make house calls." Following was the Centennial banquet at which over 800 physicians, their wives and guests enjoyed a sumptuous meal. An exciting group of Junior High School youngsters entitled, "The New Directions," sang their hearts out to inspire the audience. Presidents of county medical societies and other dignitaries were introduced. Dr. Sam Day, alias Abel S. Baldwin, received the Certificate of Merit; Dr. Merrill Wilhoit was given the Certificate of Appreciation, and Dr. Clem Cornelius Benton, who has practiced medicine in Fort Pierce for almost half a century, was given the A. H. Robins Award for

Outstanding Community Service by a Physician. He is the second black physician to be so honored by the Association. The Distinguished Layman's Award was given to Prevost Alexander Coulter, a newspaper reporter and columnist from Pensacola. Following the awards, many sat and listened, and some danced to the swing and sway music of Sammy Kaye until 1:00 a.m.

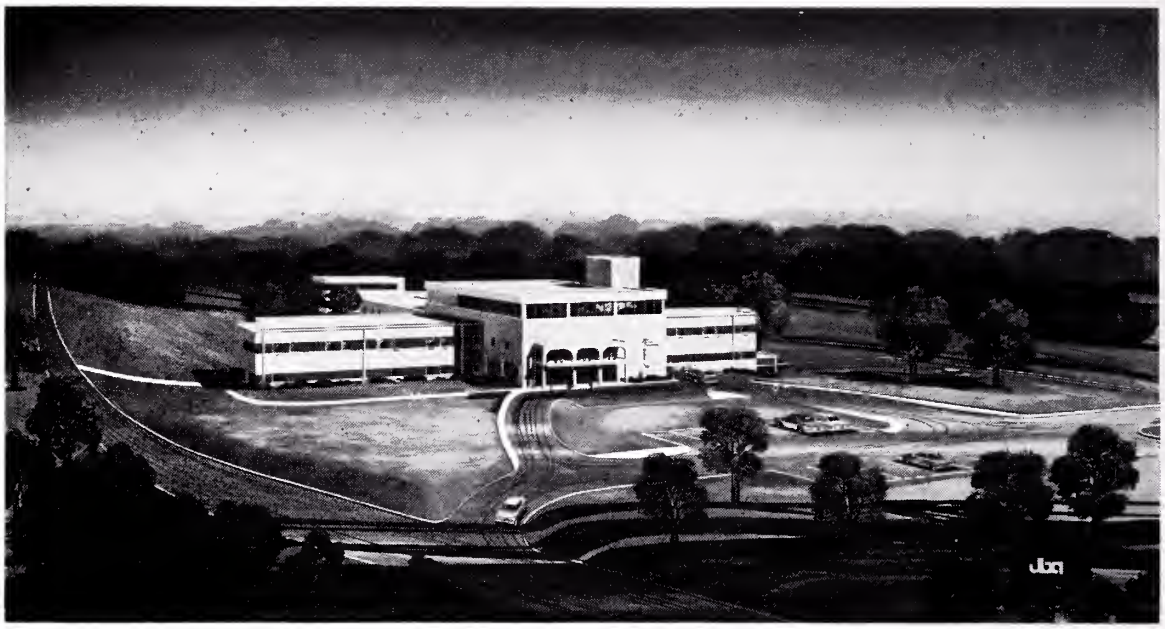
During the second session of the House of Delegates on Saturday, a resolution was introduced to amend FMA rules so that county medical societies could accept osteopaths as members. This was tabled. In an unprecedented move, about which only a privileged few had advance knowledge, the second session of the House was interrupted for a few minutes by a special academic convocation of the University of Florida. Decked out in their colorful academic robes, Health Affairs Vice President Ed Ackell; medical college Dean, Chandler Stetson; University of South Florida School of Medicine Dean, Donn L. Smith, and standing in for University of Miami School of Medicine Dean Papper, Assistant Dean, Bernard Fogel, conferred upon FMA Executive Vice President, W. Harold Parham, the degree of Doctor of Health Administration in recognition of his many contributions over a quarter century of service as an FMA staff member. At this session, Joe Von Thron introduced his council chairmen, Board of Governors and others who had helped him throughout his year as president. The ceremony of installing Thad Moseley as the new president was followed by his inaugural address.

The scientific sessions were interesting and attracted large numbers of physicians who not only stayed awake but kept their speakers alert by asking questions to further validate the finer points of each paper.

Sunday morning, after a prayer breakfast, the issue before the House of Delegates was Professional Standards Review Organizations. Dr. Zellner proposed that the "P" in PSRO was as far from the "P" in PMUR as purgatory is from paradise. There was unanimity on parts of the PSRO proposal, one being that "the FMA reaffirm its support of Peer Medical Utilization Review as an effective means of promoting and assuring quality medical care." A second resolve that "FMA unequivocally and emphatically reject the PSRO substitute for peer review" was passed. A third resolution opposed by the metropolitan areas of Dade, Duval and Escambia counties was amended to include the words "and the FMA and its foundations shall not participate." There was a long and bitter debate over this which was concluded with passage of the resolve without the amendment by a margin of about a dozen votes. This resolution stated that "the FMA encourage its membership to exercise their option not to participate in PSRO." This was concluded by a resolve that "the FMA members individually and collectively promote the repeal" of the PSRO law. A concluding paragraph stated, "That for a period of one year the Board of Governors seek no amendment, seek no injunctions against any new regulations and seek no statewide PSRO support system." This sent some delegates home to their own societies with the unresolved question of how to continue their prior work in setting up planning prototypes for PSROs. Hopefully, to maintain a united organization, these societies, as already Duval has done, will defer such actions until further directions from FMA emerge. The new Speaker of the House, Lou Murray, adjourned the meeting and a half hour later, Thad Moseley, the new president, held his first Board of Governors meeting at which time he introduced his new and old members. These included Vernon B. Astler, President-Elect; Irving M. Essrig, Vice President; Joseph C. Von Thron, Immediate Past President; William J. Dean, Past President; Theodore J. Marshall, representing District A; Jack A. MaCris, District B; T. Byron Thames, District C, and Richard C. Dever, District D. Francis T. Holland, AMA Delegate remained as an Advisory member; Louis C. Murray, Speaker of the House; Charles J. Kahn, Vice Speaker; Joseph G. Matthews, Chairman of the Blue Shield Board, and Eugene G. Peek Jr., representing Department of Health and Rehabilitative Services complete the board except for one vacancy who is yet to be appointed.

It was a meeting packed full of inspiring addresses, dedication, music, education, hard work from the full time staff, and the reunion of friends from across the state. We won't have another like it for another one hundred years, but next year will have the same opportunities and it will be the better by your attendance. Why not make plans now to attend? The dates are April 23-27, 1975.

C. M. C.



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MEETINGS

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JUNE

Clinical Pathological Conference — Management of Severe Infection, June 7, A. Vance Morgan Educational Center, Miami. For information: Division of Continuing Medical Education, South Miami Hospital, 7400 S.W. 62nd Ave., Miami 33143

JHEP Regional Continuing Education Seminars, June 14-15, St. Augustine. For information: James J. DeVito, M.D., Suite 4 Doctors Bldg., St. Augustine 32084

Eighth Annual Workshop in Electrocardiography, June 17-22, Sheraton Olympic Villas, Orlando. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

JHEP Neurology Seminar, June 22-23, Schultz Auditorium, St. Vincent's Hospital, Jacksonville. For information: Jacob Green, M.D., 2105 Park St., Jacksonville 32204 or JHEP

JULY

Upper and Lower Extremity Amputation Surgery and Amputation, July 17-21, University of Miami School of Medicine.*

AUGUST

Postgraduate Obstetric-Pediatric Seminar, Aug. 15-17, Pier 66 Hotel, Fort Lauderdale. For information: A. F. Caraway, M.D., P.O. Box 210, Jacksonville 32201

▶ Western Hemisphere Nutrition Congress IV, Aug. 19-22, Americana Hotel, Miami Beach. For information: AMA Council on Foods & Nutrition, 535 N. Dearborn St., Chicago 60610

Pediatric Postgraduate Seminar, Aug. 27, Tallahassee Memorial Hospital, Tallahassee. For information: Tallahassee Memorial Hospital, Tallahassee 32306

SEPTEMBER

Teaching Conference in Radiology, Sept. 11-15, Doral Country Club, Miami*

Postgraduate Seminar in Pediatric & Adult Urology, Sept. 23-26, Playboy Plaza Hotel, Miami*

Third Annual Postgraduate Course in Gastroenterology (Dates not decided), University of Miami School of Medicine*

By Arrangement: In-Service Tutorials in Family Medicine; Neonatology; Oncology, Ophthalmology; Otolaryngology; Pediatric Cardiology; Radiology; Renal Disease, Hypertension and Renal Dialysis; Urology*

By Arrangement: On-Site Community-Hospital Program: "A Positive Approach to Cancer Diagnosis and Treatment." University of Miami School of Medicine, the Comprehensive Cancer Center of Greater Miami, National Cancer Institute, U.S. Public Health Service, and co-sponsored by the American Cancer Society, Florida Division*

By Arrangement: Visiting Lecturers Program—a program designed to provide continuing education based on specific requests from local medical groups and hospitals*

OCTOBER

▶ American College of Gastroenterology, Oct. 20-23, Americana Hotel, Miami Beach. For information: Mr. Daniel Weiss, 299 Broadway, New York 10007

▶ American College of Surgeons, Clinical Congress, Oct. 21-25, Miami Beach. For information: C. Rollins Hanlon, M.D., 55 E. Erie St., Chicago 60611

Reconstruction in and About the Orbit, Oct. 25-26, Innshooke, Florida (Tampa area), University of Florida College of Medicine**

Intensive Colposcopy, Oct. 25-27, Sonesta Beach Hotel, Key Biscayne*

Program for Foreign Medical Graduates, Oct. 28, University of Miami*

▶ American Society of Therapeutic Radiologists, Oct. 30-Nov. 4, Sonesta Beach Hotel, Key Biscayne. For information: Sheila A. McGing, 20 N. Wacker Dr., Rm. 2920, Chicago 60606

NOVEMBER

▶ Interstate Postgraduate Medical Association of North America, Nov. 4-7, Diplomat Hotel, Hollywood. For information: Mr. Roy T. Ragatz, Box 1109, Madison, Wisc. 53701

Hand Surgery—1974, Nov. 15-17, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Miami*

DECEMBER

"Changing Concepts in Infectious Diseases for Obstetrics & Gynecology," Dec. 5-6, Hilton Hotel, Gainesville**

▶ Southern Surgical Association, Dec. 9-12, Boca Raton. For information: W. Dean Warren, M.D., 1364 Clifton Rd., N.E., Atlanta, Ga. 30322

13th Biennial Cardiovascular Seminar—"Tools and Techniques of the Practicing Cardiologist," Dec. 12-14, Sheraton Four Ambassadors Hotel, Miami. For information: Thomas J. Noto Jr., M.D., 5080 Biscayne Blvd., Miami 33137

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▶ National meetings being held in Florida.

Other Approved CME Meetings

Neonatal Care—1974 (Wednesday) 7:30 p.m.-10:00 p.m., Tampa General Hospital, Tampa

Pediatric Grand Rounds (Friday, holidays excluded) 9:15 a.m.-10:00 a.m., University Hospital, Jacksonville

Pediatric Conference (Wednesday) 9:15 a.m.-10:00 a.m., Jacksonville Children's Hospital, Jacksonville

Graduate Level Courses in Family Practice (Weekdays), University of Miami School of Medicine*

Weekly Teaching Conferences (Tuesday), Morton E. Plant Hospital, Clearwater

Peer Teaching Conferences (Wednesday), St. Vincent's Hospital, Jacksonville

In-Service Tutorial in Pediatric Cardiology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Neonatology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Radiology (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer Diagnosis & Treatment (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer In-Hospital Training Program (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Otolaryngology (Arranged), University of Miami School of Medicine*

Family Practice Grand Rounds (1st 3 Thursdays), St. Joseph's Hospital, Tampa

Consultant Teaching Seminars (Weekly), Alachua General Hospital, Gainesville

In-Service Training in Family Medicine (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Cardiology (Arranged), University of Miami School of Medicine*

Courses of Instruction in Coronary Care for Practicing Physicians (Arranged), University of Miami School of Medicine*

Practical Aspects of Family Medicine (Arranged), University of Miami School of Medicine*

Cardiac Conferences (Tuesday) 4:30 p.m.-5:30 p.m., North Florida Regional Hospital In-service Classroom, Gainesville

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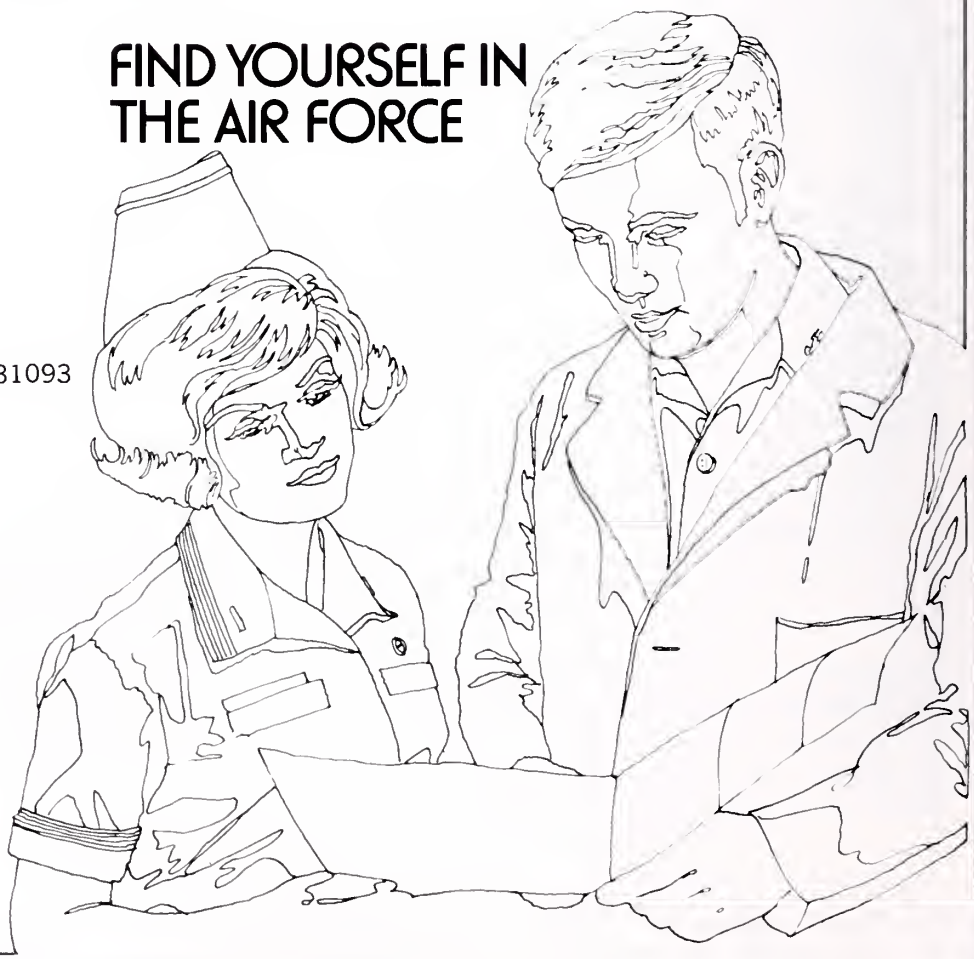

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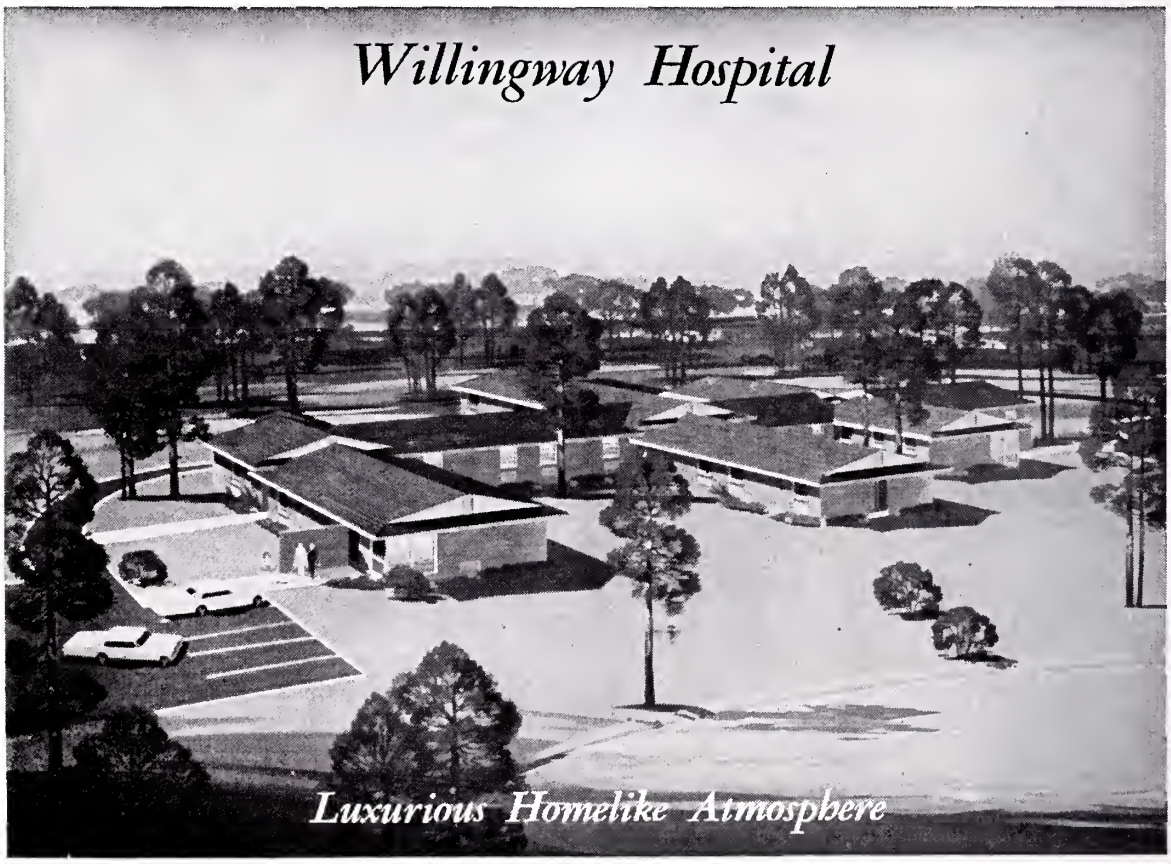

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Letters

To The Editor: The support of the doctors of Florida has been most heartening for the Florida Special Olympics for the retarded and handicapped.

By this "open letter" to you I would hope that you would be able to publish the names of the individual doctors who have been so helpful over the past three years of the Florida Special Olympics.

The State Meet will be held in Gainesville, June 14th and 15th, in which there will be perhaps some 2,500 participants and another perhaps 2,500 supporters in attendance. This is to invite the entire medical profession and their friends and relatives to attend this Meet—it may be the experience of their life.

T. Norley, M.D.
West Palm Beach

Editor's Note: An enclosed list of names of doctors who helped in the Florida Special Olympics would cover two Journal pages and due to lack of space had to be omitted.

To the Editor: The response to "I Don't Take Medicaid" was beyond belief. I think it would be worthwhile to establish some regular communication with our community of Florida physicians through the Journal, therefore, I am preparing a series of articles for the future that I will deliver to you before the first of each month.

M. E. Morrow, M.D.
State Medical Consultant
Department of Health &
Rehabilitative Services
Jacksonville

To the Editor: Would you please publish the following request in your journal:

"Again, this year I am compiling case reports of allergic reactions to biting insects, i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc. I am also interested in reactions to the imported and Southern Fire Ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports, the type of reaction and complications, if any, the age, sex, and race of the patient, the site of the bite(s), the season of the year, the immediate symptoms, the skin test results, desensitization results, if any, and any associated other allergies. Send this information to the following address: Claude A. Frazier, M.D., 4-C Doctors' Park, Asheville, N.C. 28801."

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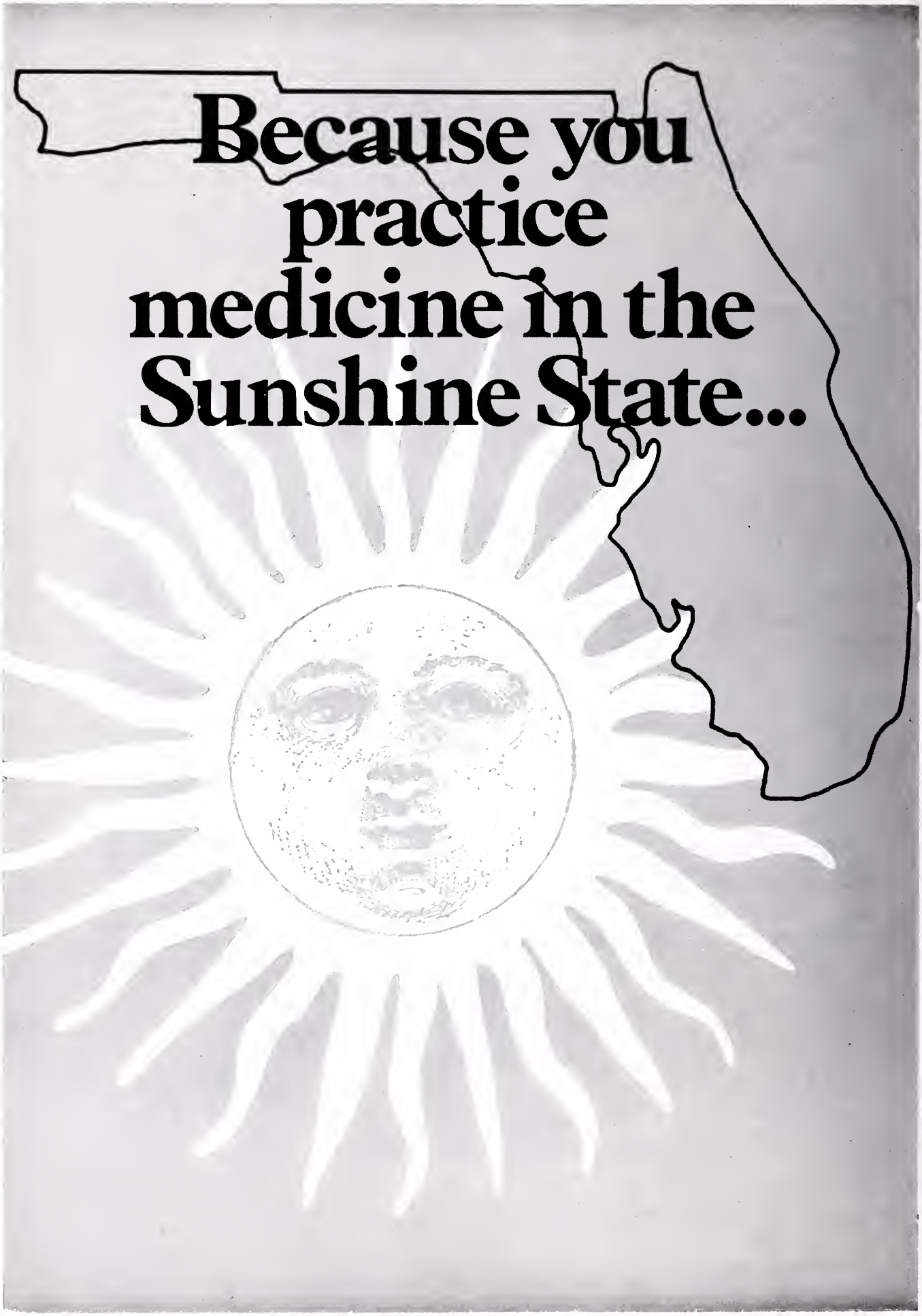
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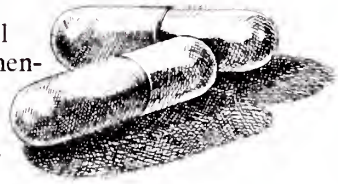

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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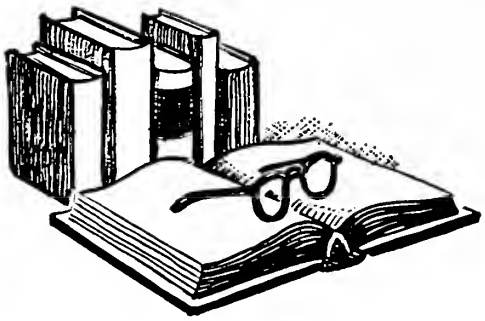

Book Reviews

Family Planning Education, Parenthood and Social Disease Control by Charles William Hubbard, B.S., M.P.H. 173 pages. 48 Illustrations. Price $3.95. St. Louis, The C. V. Mosby Company, 1973.

This small handbook (173 pages) on the four areas concerning the sexual aspects of living is an excellent one that serves a definite need. Mr. Hubbard covers these areas of sexual education briefly but well and with a minimum of technicality. A good description of male and female anatomy and function starts this book.

The various forms of contraception, the advantages and disadvantages of the different methods, failure rates and the risks are well presented. Of a special interest is the discussion concerning the risk of taking birth control pills versus the risk of pregnancy, for here one will find the justification for their wide-spread usage.

Sterilization of the male and female by different methods is presented and discussed in detail. I would differ with his comment that vaginal tubal ligation in the female is not as effective as the other methods, but otherwise, it is well done.

The section on abortion was written before the Supreme Court handed down its far reaching decision last year; however, such subjects as background, counseling and psychological effects, plus terminology in the techniques of abortion are explained.

Venereal diseases are discussed in detail including pictures of the various lesions which are helpful and serve as an excellent means of review of the five classical diseases.

This book will serve well its intended purpose of putting together into one source a great deal of information that will enable individuals, educators, and health care personnel, to help reduce human waste, ignorance and suffering. I highly recommend it.

ROBERT E. MCCAMMON, M.D.
TAMPA

The Well Body Book by Mike Samuels, M.D. and Hal Bennett. 350 pages. Illustrated. Price $5.95. New York, Random House/Bookworks, 1973.

The authors of this book probably wish this to become a home medical adviser to the counter-culture. The printing style and format are reminiscent of the *Last Whole Earth Catalog*.

This book contains mixtures of yoga, massage, and modern medicine. Illustrations show persons in familiar dress of the "now generation" with, for example, males having long hair, mustaches, and tank tops.

There are even suggestions for telling your doctor that he is dehumanized and dehumanizing; he makes people wait too long in drab waiting rooms. Yet, the authors make practical suggestions about common diseases and conditions, even suggesting that patients think for themselves about practical everyday solutions before calling the physician. They suggest using a physician as a resource person only.

It is unlikely that many of our patients will buy this book.

F. NORMAN VICKERS, M.D.
PENSACOLA

Correlative Neuroanatomy and Functional Neurology by Joseph G. Chusid, M.D. 429 pages. Illustrated. Los Altos, California, Lange Medical Publications, 1973.

The 15th edition of this text appearing only three years after the 14th edition, indicates that this type of approach is in great demand here as well as abroad. Besides editions in Japanese, Italian, Portuguese, and Spanish, a Polish edition is being prepared.

As stated in the preface, this volume "is meant to serve as an aid or supplement to standard neurologic texts and literature rather than as a substitute for them." The concise outline format of the previous editions has been retained and is enriched by charts, diagrams, and illustrations.

The book is divided into three major divisions: Central Nervous System, Peripheral Nerves and Autonomic System, and Principles of Neurodiagnosis, the last taking up almost two-thirds of the volume and including diagnostic and therapeutic measures. Psychiatric disorders are condensed into nine pages.

Some of the basic science presentations, particularly in the third division, are redundant and superficial. On the clinical side, the chapter on Aphasia, Apraxia, and Agnosia is excellent, but other clinical material is treated too briefly, e.g., the neurological complications of leukemia are dealt with in only two sentences.

The Appendix covers an excellent outline of the neurological examination, including an important and often neglected feature: neurologic examination of the neonate. References consisting of reference textbooks only are of limited usefulness. Figures, particularly photographs of gross specimens, are of good quality, but are not always correlated with the text. In Chapter 29 there are four pictures which are not mentioned in the text and appear to have little relationship to it.

The volume is a useful handbook for the beginner in clinical neurology although most topics presented here are adequately covered in standard neuroanatomy and physiology textbooks. The clinical material is often too briefly given even for the student's purposes, but, then again, it is meant to be used as a "supplement" of the regular texts only.

EVA GYORI SCHIFF, M.D.
MIAMI

Gastroenterology by I. A. D. Bouchier, M.D., 292 pages. Price $9.75. Baltimore, Williams & Wilkins Company, 1973.

This series of soft-bound medical textbooks called Concise Medical Textbooks are stated on the cover to "provide readable and up-to-date accounts of the essentials of a subject. They are written by experienced lecturers and well-known clinicians."

The problem with a small book such as this is that it presents only a small part of the subject in a concise manner, much as information is presented in standard textbooks of medicine. This book might be helpful to supplement a basic lecture series but would not stand alone. For example, peptic ulcer including complications and surgery covers 28 pages.

F. NORMAN VICKERS, M.D.
PENSACOLA

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

The Ethics of Genetic Control, Ending Reproductive Roulette by Joseph Fletcher. 240 Pages. Price $1.95. New York, Anchor Press/Doubleday, 1974.

Handbook of Poisoning by Robert H. Dreisbach, M.D., Ph.D. 517 Pages. Illustrated. Price $6.50. Los Altos, Calif., Lange Medical Publications, 1974.

Clinical Research for All by Cyril Maxwell, M.B., Ch.B. 165 Pages. Illustrated. Price $8.00. Northampton, England, Cambridge Medical Publications Limited, 1973.

Practical Spanish for Medical and Hospital Personnel by Marguerite D. Bomse and Julian H. Alfaro. 176 Pages. Illustrated. Price $4.50. New York, Pergamon Press, Inc., 1973.

Hyperbaric Oxygenation—The Uncertain Miracle by Vance H. Trimble. 236 Pages. Illustrated. Price $6.95. Garden City, N. Y., Doubleday & Company, Inc., 1974.

Cardiovascular Diseases, Guidelines for Prevention and Care edited by Irving S. Wright, M.D. and Donald T. Fredrickson, M.D. 404 Pages. Price $6.95. Washington, D. C., U.S. Government Printing Office.

The Dangerous Sky, A History of Aviation Medicine by Douglas H. Robinson, M.D. 292 Pages. Illustrated. Price $15.00. Seattle, University of Washington Press, 1974.

The Malnourished Mind by Elie A. Shneour. 216 Pages. Price $6.95. Garden City, N. Y., Anchor Press/Doubleday, 1974.

Medicare & Social Security: What You've Got Coming by Bruce Biossat. 114 Pages. Price $1.95. Garden City, N. Y., Doubleday & Company, Inc., 1973.

Arthritis, Complete, Up-to-Date Facts for Patients and Their Families by Sheldon P. Blau, M.D. and Dodi Schultz. 176 Pages. Price $5.95. Garden City, N. Y. Doubleday and Company, 1974.

Aphasia, My World Alone by Helen Harlan Wulf. 144 Pages. Illustrated. Price $7.50. Detroit, Wayne State University Press, 1973.

Emergency Medical Services: Behavioral and Planning Perspectives edited by John H. Noble Jr., Ph.D.; Henry Wechsler, Ph.D.; Margaret E. LaMontagne, M.S.N. and Mary Anne Noble, D.N.Sc. 595 Pages. Illustrated. New York, Behavioral Publications, 1973.

Current Pediatric Diagnosis & Treatment, 3rd Edition by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,020 Pages. Illustrated. Price $12.00. Los Altos, California, Lange Medical Publications, 1974.

Information for Authors

Manuscripts should be submitted to the editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

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INTERNIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-619, P. O. Box 2411, Jacksonville, Florida 32203.

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Miscellaneous

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PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccousukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

FAMILY PRACTITIONER OR INTERNIST WANTED to join newly formed clinic in newly developed ITT community. Full or part time. Excellent opportunity for retired physician to supplement income. Financial arrangement flexible. Write or call: Jack Dunn, M.D., 4 Carol Court, Palm Coast, Flagler Beach, Florida 32036. Phone (904) 445-3868.

WANTED: E. R. Physician for day shift, ten hours per day, five days a week. Must have Florida license and provide references. Write or call, Administrator Highlands General Hospital, P.O. Drawer 2066, Sebring, Florida 33870. Phone: (813) 385-6101.

VACANCIES EXIST FOR PHYSICIANS in new Veterans Administration Ambulatory Care Clinic being activated in Orlando, Florida. Very active, comprehensive and innovative quality patient care is the goal of this clinic. Clinic sponsored by VA Hospital, Tampa, Florida, with University of South Florida School of Medicine affiliation. Licensure in any state; salary dependent upon individual qualifications; excellent fringe and retirement benefits; nondiscrimination in employment. Inquiries should be directed to C. W. Silverblatt, M.D., VA Hospital, 13000 N. 30th St., Tampa, Florida 33612. Phone: (813) 971-4500, Ext.: 131.

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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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Bactrim™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

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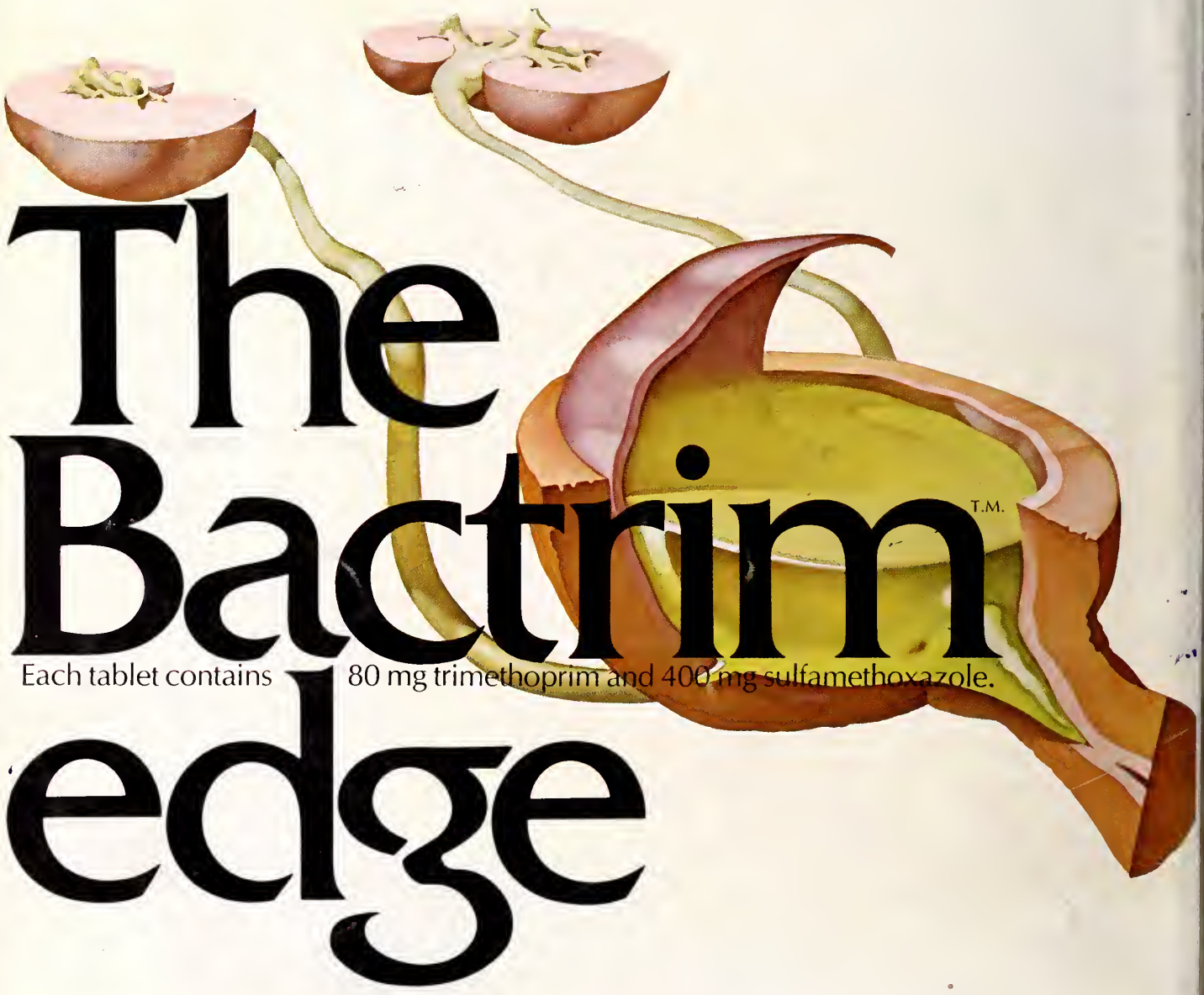

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

A high assurance of antibacterial activity
in cystitis, pyelonephritis and pyelitis diagnosed as chronic and due to susceptible organisms

Before prescribing, please cons
a summary of which appears or

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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION, INC. JULY 1974

COLLEGE OF PHYSICIANS
PHILADELPHIA
AUG 1 - 1974
MDS

PROCEEDINGS ISSUE

Everybody experiences psychic tension.

Most people can handle this tension.

Some people develop excessive psychic tension and need your counseling,

and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

You should be aware of the possibility of side effects in some patients and should consult the complete product information before prescribing.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 100.

Valium®
(diazepam)

To help you manage excessive psychic tension

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JULY, 1974 • VOLUME 61 • NUMBER 7

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JULY COVER—The painting, entitled "Herndon's Fernery Road," by Mrs. Matthew A. (Judith) Moroz of DeLand, won the Editor's Award at the Woman's Auxiliary Eighth Annual Benefit Art Show during the FMA Annual Meeting, May 8-12, 1974 in Hollywood.

President's Page

We Must Work Together

In its deliberations at the 100th Annual Meeting of the Florida Medical Association, your House of Delegates directed that *through the next year:* (1) All efforts of the membership and of the Board of Governors be directed toward repeal of Section 249, Federal Public Law 92-603, the Bennett amendment, which provides for Professional Standards Review Organizations. (2) Your state PSRO Committee seek no state support system. (3) The individual physician be urged to exercise his option not to participate in PSRO. (4) This Association seek no injunction against any regulation concerning PSRO.

The delegates re-affirmed their support of Peer Medical Utilization Review as an effective means of promoting and assuring quality care and emphasized that future legislative efforts should be directed toward developing a system not controlled by Federal organizations.

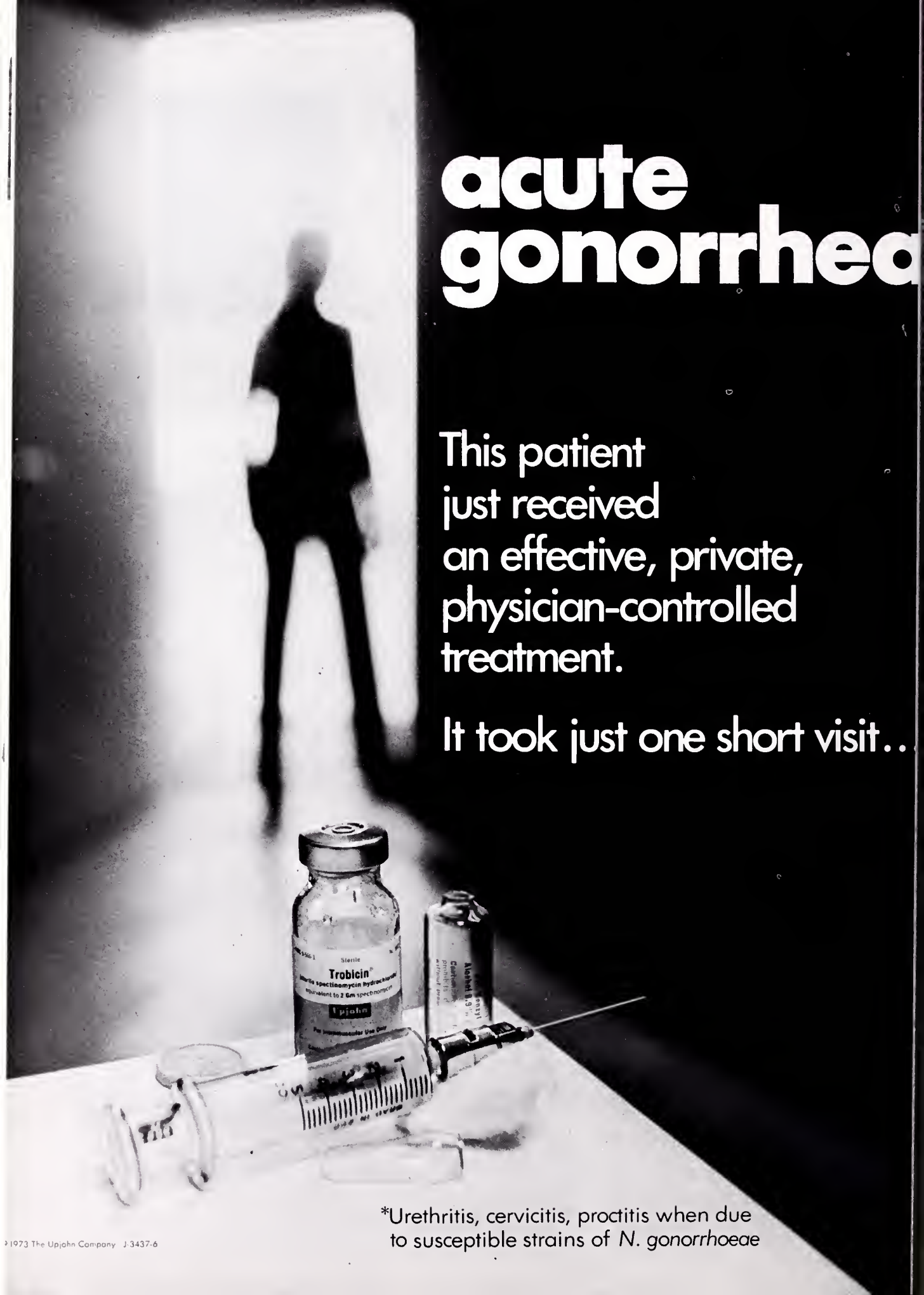
A copy of the substitute resolution (74-8) as passed by the House has been sent to each county medical society as a guide for its governing body.

The delegates voted upon each segment of the resolution separately following searching discussion and forceful debate. The decision reached is of the utmost importance for it must be supported by each physician if we are to prevent fragmentation of our membership into disparate groups.

The Board of Governors of the Duval County Medical Society and the Society's Foundation for Medical Care has approved a motion which states "That the Foundation for Medical Care in Duval County in cooperation with the Duval County Medical Society continue to develop the open panel, prepaid health plan concept and continue to refine the mechanisms of peer review. Furthermore, that there cease to be any activities relating to Professional Standards Review Organizations, including the planning contract, until the next meeting of the House of Delegates of the Florida Medical Association."

The FMA Officers and Board of Governors need this kind of support in the year ahead. The House of Delegates has given us a specific directive; as members of our county medical societies and of the Florida Medical Association we must work together to be effective.

Thad Moseley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gonorrhea
This patient
just received
an effective, private,
physician-controlled
treatment.
It took just one short visit...
Sterile
Trobicin
1 gram
*Urethritis, cervicitis, proctitis when due
to susceptible strains of N. gonorrhoeae
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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramusculor Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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DEPARTMENT OF MEDICINE

announces a **REVIEW COURSE** on

"Fundamental and Clinical Aspects of Internal Medicine"

October 6-19, 1974

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Co-Directors: William J. Harrington, M.D. and Eric Reiss, M.D.

Program Coordinator: Jose S. Bocles, M.D.

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Schedule:

The course will consist of daily sessions, Monday through Saturday for two successive weeks. On each day beginning at 8:00 a.m., fundamental and core material on a given topic will be presented. After a coffee break (10:00-10:30 a.m.), recent advances will be reviewed from 10:30 a.m. to 1:30 p.m.; from 5:00 p.m. to 7:00 p.m., there will be amply illustrated reviews on such relevant topics as ophthalmologic, endoscopic, dermatologic, radiologic, etc., manifestations of internal diseases.

Hotel:

A limited number of suites at the Sheraton-Four Ambassadors Hotel have been made available at a special rate of $19/28 per day. A hotel reservation form will be promptly forwarded with the confirming registration.

This course is accredited on an hour by hour basis toward the AMA's Physician's Recognition Award.

Registration

Fee for the entire course (12 Days) $400
Minimum registration of 2 days required ($80.00):

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Registration will be limited, therefore, priority will be given to applicants enrolling for entire course.

For information and application write to:
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University of Miami School of Medicine
P.O. Box 520875, Biscayne Annex
Miami, Florida 33152
Phone 305/547-6063

Letters

Medicaid

Dear Dr. Morrow: I read with interest your article in the April issue of JFMA. I don't accept Medicaid either, but in a slightly different vein than your last paragraph. Most of our leaders in conservative organized medicine feel "the taking of assignment" was not in the physicians' best interest, so I have refrained and if we don't listen to those who are our spokesmen, then why have such organizations?

If you and our Government hadn't been so slippery, there could still have been provisions for the indigent to receive his check and then in turn pay me, so I don't buy your fancy last paragraph. My indigent simply are *not charged*—so they aren't aware of any problems and they are getting medical care. It's too bad you couldn't put your emphasis, interests, expertise and talents to *this aspect* of the problem and help those of us who would really like to help.

Kenneth C. Kiehl, M.D.
Sarasota

Snakebites

To the Editor: In April of 1968, the JFMA printed a symposium on snakebites and suggested treatment. Since then many writers have stressed the importance of corticosteroids in these cases. In my sleuthing, I find enough disagreement in the proper dosage to be somewhat skeptical. Some say it should be used with antivenom. others say the steroid will suffice. Where do we stand with cryotherapy and tourniquet use?

Wishing to remain contemporary in my treatment, I would hope you could question the sages of this topic and give me and our staff some feedback with their replies.

B. F. Dicken, M.D.
Chief of Staff
Humphreys Memorial Hospital
Fernandina Beach

Dear Earthdocs:

I was there at your Centennial Celebration of the Flatland Medical Association. I hope you saw and recognized me because I recognized those cheerful, happy members who attended. I carried home my memorial keyholder and souvenir drinking glass with the Flatland Medical Association seal.

The reference committees were interesting and informative. The deliberations on PSRO were exciting and heated. They reminded me of similar meetings of the Martian Medical Association. When important issues arise in Mars, our Martiandocs frequently get into heated debates. My observations have shown that the emotionality of our meetings were frequently inversely proportional to the amount of good information we had available. I wish that I could go back in Martian history and give you some sage advice about your present problem. However, we have no similar experience so you will have to decide this on your own. Good luck. I will be around to watch the outcome.

One impressive note, pardon the pun, was the State Auxiliary Report given by outgoing President, Mrs. William Mathews. Her report given in song was truly delightful and informative. I suggest she offer singing lessons to officers and delegates, particularly B. S. docs.

I could not end this letter without congratulating last year's President, Joe Von Thron on an excellent year and an excellent meeting. His speakers were superb. I look forward to seeing President Thad Moseley in action. I look for an exciting year in this critical period of medicine.

The lecture by Dr. William Masters, sexologist, was doubly interesting to me. I noted the standing-room-only crowd. It has been said that everyone is an expert on medicine, politics, religion, and sex; however, it was apparent that many persons wished to increase their knowledge on this interesting and exciting subject. I regret, however, that I have no words of wisdom to give you here either since we Martians reproduce by binary fission. It is obvious that we are missing lots of fun and envy you earthdocs. See you around!

Sincerely,
Martiandoc

May was "Blood Pressure Month," and Gov. Reubin Askew practiced what he proclaimed by allowing Joseph C. Von Thron, M.D., then President of the Florida Medical Assoication, to take a reading from his right arm. Judging from the countenances of both doctor and patient, the finding must have been satisfactory. Looking on are (left to right): Gerold L. Schiebler, M.D., Director of the Division of Children's Medical Services who represented the Florida Heart Association at the proclamation ceremony; Marshall E. Groover Jr., M.D., of the Florida Division of Health and Thomas E. McKell, M.D., Health Services Coordinator for the Florida Department of Health and Rehabilitative Services.

AMA News Awards

Prevost Coulter, a writer for the Pensacola News-Journal, has received honorable mention in the 1973 American Medical Association Journalism Awards Program. The awards were presented on June 25 at the annual meeting of the National Association of Science Writers in Chicago.

The awards are presented in various categories annually to recognize outstanding contributions to a better understanding of the science and art of medicine.

Mr. Coulter was honored by the Florida Medical Association during the 100th Annual Meeting in May when he was presented with the Association's second "Distinguished Layman" award.

Speakers on Controlled Substances

The Federal Government is making available speakers to professional organizations who wish to have the Controlled Substance Act of 1970 clarified.

Requests for speakers should be addressed to: Mr. Anthony R. Acri, Drug Enforcement Administration, U. S. Department of Justice, 201 N.E. Twelfth Street, Miami, Fla. 33132.

Dr. Jere Annis Honored

Jere W. Annis, M.D., of Lakeland, a former President of the Florida Medical Association, has been honored as "Distinguished Internist of the Year" by the American Society of Internal Medicine.

The honor was bestowed at the Society's Annual Meeting in San Francisco this spring. Dr. Annis is managing partner of the Watson Clinic in Lakeland and is a member of the Board of Trustees of the American Medical Association.

John V. Verner, M.D., Chairman of the Watson Clinic's Department of Medicine, was elected a trustee of the Society of Internal Medicine.

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At Wolf Laurel, resting in the shadows of the highest privately owned mountain in the Carolinas, 5516 ft. Big Bald, your family can enjoy swimming, tennis, horseback riding (reasonable fees), hiking, or just relaxing—while you play golf (reasonable fees). Stay in the Wolf Laurel Inn or rustic log cabins and dine in our mountaintop restaurant and lounge. Next winter enjoy our 3-lift ski run. We think you'll like Wolf Laurel. After wandering through thousands of acres of our mountain property, you may want to select a homesite and spend a lifetime of vacations with us. We're located 27 miles north of Asheville, N.C. on U.S. 23. For reservations and/or color brochure, call 704-689-4111 or write Fondren Mitchell, Pres., Wolf Laurel, Dept. FM, Route 3, Mars Hill, North Carolina 28754. By the way, our 18-hole golf course has the highest hole east of the Rockies.

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FM

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Health Affairs Chief at Florida

Kenneth F. Finger, Ph.D., has been named interim vice president for health affairs at the University of Florida.

Dr. Finger, Dean of the College of Pharmacy since 1968, will succeed Edmund Ackell, D.M.D., M.D. Dr. Ackell leaves this month to become vice president for health affairs at the University of Southern California in Los Angeles.

Meanwhile, a 13-member search committee has been appointed to recruit a permanent successor to Ackell.

Hippocratic Award

Homer Knizley, M.D., of Gainesville, has been named to receive the 1974 Hippocratic Award for Teaching Excellence by the graduation class at the University of Florida College of Medicine.

Dr. Knizley served as Assistant Professor of Medicine and Chief of the Division of Endocrinology and Metabolism until early this year, when he entered private practice in Gainesville. He remains a member of the College's volunteer faculty. Presenting the award to Dr. Knizley, (left) is Kevin Soden, senior class president, (center), Dr. Knizley and to the right is Mark Slatkoff, Awards chairman.

"...a more satisfactory treatment..."[1]

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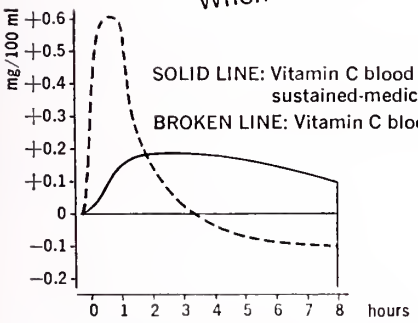

SOLID LINE: Vitamin C blood levels obtained with sustained-medication capsules (CEVI-BID).

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*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

JULY

Upper and Lower Extremity Amputation Surgery and Amputation, July 17-21, University of Miami School of Medicine.*

AUGUST

Postgraduate Obstetric-Pediatric Seminar, Aug. 15-17, Pier 66 Hotel, Fort Lauderdale. For information: A. F. Caraway, M.D., P.O. Box 210, Jacksonville 32201

Diagnostic Radiology for the Emergency Department, Aug. 18-23, Sheraton Olympic Villas, Orlando*

▶ Western Hemisphere Nutrition Congress IV, Aug. 19-22, Americana Hotel, Miami Beach. For information: AMA Council on Foods & Nutrition, 535 N. Dearborn St., Chicago 60610

Pediatric Postgraduate Seminar, Aug. 27, Tallahassee Memorial Hospital, Tallahassee. For information: Tallahassee Memorial Hospital, Tallahassee 32306

"Growth, Growth Diagnosis and Pediatric Endocrinology," Aug. 30-31, Sacred Heart Children's Hospital, Pensacola. For information: Pensacola Educational Program, 5151 N. Ninth Ave., Pensacola 32504.

SEPTEMBER

Teaching Conference in Radiology, Sept. 11-15, Doral Country Club, Miami*

Postgraduate Seminar in Pediatric & Adult Urology, Sept. 23-26, Playboy Plaza Hotel, Miami*

Third Annual Postgraduate Course in Gastroenterology (Dates not decided), University of Miami School of Medicine*

By Arrangement: In-Service Tutorials in Family Medicine; Neonatology; Oncology, Ophthalmology; Otolaryngology; Pediatric Cardiology; Radiology; Renal Disease, Hypertension and Renal Dialysis; Urology*

By Arrangement: On-Site Community-Hospital Program: "A Positive Approach to Cancer Diagnosis and Treatment." University of Miami School of Medicine, the Comprehensive Cancer Center of Greater Miami, National Cancer Institute, U.S. Public Health Service, and cosponsored by the American Cancer Society, Florida Division*

By Arrangement: Visiting Lecturers Program—a program designed to provide continuing education based on specific requests from local medical groups and hospitals*

OCTOBER

Fundamental and Clinical Aspects of Internal Medicine, Oct. 6-19, Sheraton Four Ambassadors Hotel, Miami*

▶ American College of Gastroenterology, Oct. 20-23, Americana Hotel, Miami Beach. For information: Mr. Daniel Weiss, 299 Broadway, New York 10007

▶ American College of Surgeons, Clinical Congress, Oct. 21-25, Miami Beach. For information: C. Rollins Hanlon, M.D., 55 E. Erie St., Chicago 60611

Reconstruction in and About the Orbit, Oct. 25-26, Innshooke, Florida (Tampa area), University of Florida College of Medicine**

Intensive Colposcopy, Oct. 25-27, Sonesta Beach Hotel, Key Biscayne*

Program for Foreign Medical Graduates, Oct. 28, University of Miami*

▶ American Society of Therapeutic Radiologists, Oct. 30-Nov. 4, Sonesta Beach Hotel, Key Biscayne. For information: Sheila A. McGing, 20 N. Wacker Dr., Rm. 2920, Chicago 60606

NOVEMBER

▶ Interstate Postgraduate Medical Association of North America, Nov. 4-7, Diplomat Hotel, Hollywood. For information: Mr. Roy T. Ragatz, Box 1109, Madison, Wisc. 53701

Hand Surgery—1974, Nov. 15-17, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Miami*

▶ American Association for Clinical Immunology and Allergy, Nov. 21-24, Pier 66, Ft. Lauderdale. For information: John L. Dewey, M.D., P.O. Box 912, DTS, Omaha, Nebraska 68101

Progress and Prospects in Health Care Distribution Systems, Nov. 25-27, Fontainebleau Hotel, Miami Beach*

DECEMBER

"Changing Concepts in Infectious Diseases for Obstetrics & Gynecology," Dec. 5-6, Hilton Hotel, Gainesville**

▶ Southern Surgical Association, Dec. 9-12, Boca Raton. For information: W. Dean Warren, M.D., 1364 Clifton Rd., N.E., Atlanta, Ga. 30322

13th Biennial Cardiovascular Seminar—"Tools and Techniques of the Practicing Cardiologist," Dec. 12-14, Sheraton Four Ambassadors Hotel, Miami. For information: Thomas J. Noto Jr., M.D., 5080 Biscayne Blvd., Miami 33137

JANUARY

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 22-25, Hyatt House, Miami Beach*

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▶ National meetings being held in Florida.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JULY, 1974 • VOLUME 61 • NUMBER 7

PROCEEDINGS

One Hundredth Annual Meeting—Florida Medical Association, Inc.
Hollywood, May 8-12, 1974

Presidential Address

JOSEPH C. VON THRON, M.D.

Mr. Speaker, ladies and gentlemen, members of the House of Delegates, and guests—

I want you to know that when I commenced to prepare to stand here before you I was tempted to make light remarks, be witty and have some entertainment and also be brief. Unfortunately, I have been unable to prepare remarks that would be witty and offer you little entertainment. The reason for my plight—and yours—can be summarized by four letters: PSRO.

Now, if I may review quickly: in 1972 the Congress of the United States enacted the PSRO legislation. In 1973 the Florida Medical Association Board of Governors considered this legislation and we found it to be unnecessary, undesirable, poorly formulated; but, faced with the alternative of having a system regulated by government appointees—as opposed to doctors working within the framework of the coordinated medical society act—we decided that maybe we should form a statewide PSRO corporation. We brought this back to the House of Delegates and in 1973 you sustained our action.

By these actions Florida medicine acted in good faith; however, HEW has responded negatively. So, in March 1974 the Board of Governors again considered the problem and decided to seek an injunction against HEW for not recognizing our statewide PSRO corporation and this currently is in process.

That brings us up to May 8, 1974. I have held many positions in Florida medicine including this year as President and I have had the privilege to sit in conferences of PSRO meetings, attend AMA PSRO conferences and visit and have effective dialogues with Presidents and leaders of other Associations and also talk with several Congressmen and Senators from other states. Having been exposed to this tremendous informational span of education I would like today to attempt

President Joseph C. Von Thron, M.D., of Cocoa Beach, delivers his Presidential Address.

Presented at First Session of the House of Delegates, 100th Annual Meeting of the Florida Medical Association, May 8, 1974.

to render you an opinion. I have had the benefit of many letters, too, and phone calls from many members of this Association. Some of them are seated here today. Some of them were polite, some of them not so polite; but all sincere and none vindictive.

I might draw an analogy of our relationship with PSRO—it reminds me of Mark Twain with his immortal description of his boyhood fight with the village bully. He said, "Blocking his fist with my eye, and thrusting my nose firmly between his teeth, I threw him heavily to the ground on top of me." Our fight with the PSRO bully, I hope, will not emulate Mark Twain.

Why was the act passed and what was wrong with it? Well, we all know it was established to monitor the medical services funded under Medicare and Medicaid. We recognize that the primary reason for enacting the law was to control costs. We know this is worthwhile—we certainly need to minimize abuses, improve utilization, reduce the cost, spending. But, before we control costs, we must identify the costs. Frequently Washington "showboating" leads to fiscal scapegoating and we must recognize that doctors in the hospitals are really not the culprits. If I may quote Caspar Weinberger, the Secretary of HEW—he said that the real culprit behind rising health costs is the Federal Government and he noted that Medicare and Medicaid have played a major role in this spiral of health care in this country.

A little county in Georgia, Liberty County, has a hospital where they have recently done a cost analysis study and they have found out that since the advent of Medicare there has been an increase per day, per patient of $11 over and above the ordinary inflationary trend that you might expect. Now this $11 affects all the patients, not just the Medicare patients, because of the regulations, the red tape, the computers, the extra people that have been necessary. If you multiply that times the number of patients we have in America, think what extra we are paying for red tape for Medicare.

You know when the cost of visiting a physician has gone up less or the same as the cost of apples or lettuce or going to the movie or getting a haircut; when the cost of all health care has gone up less than the cost of transportation or owning a home; when the cost of operating Congress has increased 100%; when Congressmen's salaries have almost doubled; when the cost of a postage stamp has tripled or going to a private college has increased 80%; and when a man who makes $10,000 a year today spends 30 minutes a day for his health care and 2½ hours a day to pay for his taxes; when people talk about having better peer review for physicians, I think they had better get it in the proper perspective. I think it is Government that needs better peer review and not the doctors.

This act also attempts to minimize abuses and improve utilization. You know that's two noble objectives, but how? I keep hearing the words, "peer review." Let me tell you what PSROs are and what they are not. The most common definition I hear is that PSRO is peer something or the other, making sure that doctors are conducting themselves like doctors are supposed to conduct themselves. Well, that is a pretty good description of what PSRO's are not. The words, "peer review," do not appear in the title as you all know. The concept was inserted later as a tentative concession because of testimony so that peers become involved if they do what their non-peers want them to do. PSRO is a Professional Standards Review Organization that is set up to be run by the Secretary of HEW. I have studied the law as have many of you and I have read commentaries on the law and the words, "under regulations prescribed by the Secretary," "as required by the Secretary," "under rules established by the Secretary," and other phrases of that sort occur 96 times in the legislation. I was afraid to let my secretary read this bill because I thought she would believe that secretaries were taking over the world.

Let me get this straight though: The FMA, the American Medical Association, and I, and many others were committed to the principle of peer review. We believe in peer review under professional direction, and programs in different medical societies of proven effectiveness should not be dismanteled just because of PSRO.

You know we have PMUR—Peer Medical Utilization Review—here in Florida—one of the finest State Committees in our Association led by a tremendous Chairman, Jim Byrnes; and they are working hard to recover many dollars in the Medicare Program. I am proud of the peer review in my own little hospital and the other hospitals across the State. My little hospital probably needs some upgrading just as other hospitals, but you know, if they changed the title from PMUR to PSRO is that going to make Jimmy Byrnes, the Chairman of our fabulous Committee any more ethical or honest or efficient? Is there going to be a sudden revelation because

PSRO is now over the door? No. He has done a tremendous job and so has that committee and we owe them a debt of gratitude as an Association. But, we need this kind of peer review and we don't need governmental non-peers.

There is another problem that has been created. There has been a serious invasion of privacy. Congressman Phillip Crane from Illinois recently addressed a medical society in Tennessee and after he concluded his remarks a doctor came up and said, "You know, your message really got across to a couple of the guests tonight." He said, "Who were they?" "Well, two of my patients—one was a clergyman and one was a lawyer and both of them are very politically liberal." He said, "Nevertheless, they were responsive to a certain portion of your discussion when you touched on confidentiality and that really grabbed them." He said, "Being their physician I can understand why they were grabbed by that remark."

But if you think I am over emphasizing the right of privacy, let me remind you of the growing abuse taking place not only by Government, but by industry, by the credit rating bureaus and by university computers. In California recently, a computer happened to beam the confidential medical file of a woman socialite into terminals all over the state. It disclosed that at a younger age she happened to be a prostitute, information that should have been restricted to her and her doctors. I assure you, in terms of salvaging this law, this PSRO bill, this is the one problem that is calculated even to run Congressmen up the wall. They don't understand the implications of an HEW bureaucrat going into our offices and looking at our Medicare and Medicaid files and though they are not covered by Medicare and Medicaid, we must permit them to look at non-Medicare and non-Medicaid files for qualitative comparison.

A psychiatrist in Bloomington, Indiana said: "We won't need an Ellsberg break-in; we'll just send one of those HEW jerks to check my records." I believe in this age when Americans have become increasingly incensed and concerned about their rights to privacy, this is the greatest shortcoming of this law.

But PSRO implementation is also taking us a giant step toward socialized medicine. Recently, studies in Sweden, which has a national health plan—an HMO or something like an HMO—indicated 8% of their gross national product is going to health care compared to 7.5 or 7.7% in our country. But they hear the same things over there—delays in getting appointments, geographically poor distribution of doctors, constantly rising costs, insufficient preventive medical care, inadequate facilities. Statistics in this country—the Harris Poll, the Gallup Poll—have shown that the main concern of the American public happens to be inflation—60% to 70% put it first on the list and then down below that were nudey bars, bussing, crime in the streets, the energy crisis and 15th on the list was national health insurance. Three percent of the people listed national health insurance and less than 1% had it near the top of the list and as far as a medical crisis existing in this country, there is none.

Mr. Nixon compounded the problem when he made his 1968 Inaugural Address. He said that if a drastic action is not taken within the next three years there will be a total collapse of the health care delivery system in America. Well, this is six years later! There are no lines of patients outside doctors or hospital doors or lying in the streets in front of pharmacies. No medical crisis exists in America. It's a term that has been foisted on us by the politicians, newspapers, the government types.

Stan Evans, a famous columnist, adopted a rule of thumb that I think is very relevant today. He said, "If you read it in the New York Times,

President Joseph C. Von Thron, M.D., holds aloft a bumper sticker which seems to epitomize the message contained in his presidential address.

you'd better check it; if you read it in the New York Times and see it as a cover story in Newsweek, it is probably wrong; but if you read it in the New York Times, see it as a cover story in Newsweek and then see it as a one hour special on NBC—you know it's wrong." I use that method to confirm that there is no medical crisis in America.

A secondary problem we must attribute to the doctors themselves. Invariably we argue they are going to do it to us anyway so let's do it to ourselves. They believe that all of a sudden the government is going to stop watching and let us do what we want to do instead of what they want us to do. The best current example of doing-it-to-ourselves philosophy is the PSRO legislation itself. For a year the American Medical Association complained about the deleterious and harmful effects of this legislation. So where did it come from, how did we get PSRO? Mr. Kennedy didn't introduce it, Mr. Javits didn't introduce it, Mr. Long didn't introduce it. It came from Mr. Bennett, a fine conservative Senator from the state of Utah who took it out of our original Medicredit Bill and he shakes his head in bewilderment as to what's happening to him. He said after all this is what the doctors wanted. Well, let me tell you how that all happened. You know articulating Congressmen and government tell us that doctors are always negative, that we should come up with positive proposals. That is not our game. They do that in the Congress of the United States and they call it compromise. We don't have to come up with positive proposals. A long time ago a Congressman in New York developed this theory and he called it Conservative Republican Alternative Proposals. Think about that—Conservative Republican Alternative Proposals. The acronym, CRAP, adequately describes Conservative Republican Alternative Proposals.

Another problem is the divisiveness. I am sure that Dr. Todd would agree with me that this is the most divisive piece of legislation affecting medicine in our nation's history. Our component state associations can't agree; the trustees of the AMA have been faced with a plethora of approaches in attempting to handle this problem. The AMA trustee who is charged with the problem of handling PSRO, Dr. Hunter, in a recent news release said. "The AMA is inconsistent, they have to clarify their position." Well, you can't expect them to clarify their position because they are faced with a sundry of approaches. Pennsylvania has now a statewide PSRO corporation; Georgia is for repeal; Illinois is going to have their own peer review; California has a non-participation type of idea; and Florida is after a PSRO statewide corporation.

How can you clarify? The Florida Medical Association is facing the same problem, the same divisive problems. A county in the panhandle wants to secede if we have a statewide PSRO corporation. There are two counties on the Gulf Coast that are in constant confrontation. Nobody wants to join Dade. Of course that's not new, but nobody wants to join Dade. Three counties already have in Washington applications for planning grants and in my own county of Brevard where I know everything that is going on—I found out two weeks ago that a doctor has been wining and dining the PSRO officials from Georgia and that he is trying to set up a Volusia/Brevard County PSRO corporation, and Volusia probably doesn't know. And, because of PSRO, in my position of President, I have been called this year, everything from a flaming liberal to an ultra conservative. If I'm a flaming liberal, Hubert Humphrey is an introvert.

This is where we stand today, but what are we going to do about it? Well, before we start talking about what we are going to do about it let me tell you what we are not going to do about it. First, let's not talk about doing it to ourselves. That's poor political thinking. That can't work. That's double talk. If that's going to be our policy and strategy, let's file it in a different type of rhetoric. Let's forthrightly attack this for the bad piece of legislation that it is.

There is a second solution. Don't worry about the word negative. Don't be influenced about the word negative. You know, if I'm against war, I must be for peace. If I'm against mugging and killing in Miami, I must be for serenity and moon over Miami; and if I'm against something that does violence to the quality of medical care in this country I must be for quality medical care in this country. And third, don't consider that PSRO and national health insurance are inevitable. That's a word that has been banging about and has stuck in my craw for a long time. I made my first speech against "inevitable" eight years ago and two or three physicians came up to me and said, "Joe, you know it's going to come in two or three years." Well, I have been talking about "inevitable" for eight years and we still don't have it. The reason is, don't sell the Congress of the United States short. I have been going there for

12 years and it's a different body, it's a different organization; there is more talent, there is more ability, there are more young men, there are more people with bachelor's, master's, doctor's degrees, and even the most liberal men in the Congress of the United States today are not about to involve our country in a grandiose new medical scheme that is going to cost thirty to eighty billion dollars. Congress is aware of the ever rising costs. It is aware of new terms like over-utilization and extended care facilities and Mr. Cohen's prediction is far below what we are paying today. But yet, there are those physicians who seem to take pride in their own clairvoyance in saying, "It's inevitable." God only knows who slipped that word to us but it is time to get our nose out of Borlands and get it into Funk and Wagnalls.

The fourth thing is, don't let it divide us. In the next four days we will be having deliberations and we must decide as an Association what course to follow. I hope that you are going to accept the recommendation that I'll be making in about three or four more minutes, but regardless if you do, as Dr. Todd pointed out, we need unity more than ever before in our country's history. It's time that the physicians of this country united to guard our cherished profession and our noble heritage. It's time that we ostracized that physician who individually is setting up PSRO's and exploiting the system for himself. It is time we realize that times have changed. You no longer can survive by yourself. The country doctor is gone. You have to rely on your confreres and your colleagues. So let's not forget it. You know the English doctors after World War II—85% of the vote was in and they said they would never take part in a national health scheme. Two weeks later, government types who articulate, who are cleverer than we are went into the small hamlets across Great Britain and they would go to a town and say, "there will be four surgeons on the staff of this hospital"; well there happened to be eight surgeons in the community. They also offered another carrot, "You'll get a bonus for those who will sign up first." They couldn't run fast enough, they couldn't put their names down fast enough to become members of the national health scheme. They sold out their colleagues, their profession, and their standard of living, and their income dropped. But, the major loss was their identity and their prestige in the community. And in England you no longer demand the respect and the appreciation and the admiration that a physician does in the United States, and the saddest thing about this story is that in Canada a few years later they duplicated the same act. Overnight in Quebec the doctors were conscripted. If they had had leadership in the British Medical Association, if they had had leadership in the Canadian Medical Association, it might not have happened. You know we are all on the same ship and it's a scientific fact that you can't sink half a ship—you can't sink the captain's quarters and the crew goes sailing on and ignore the fact and I don't care if you are a liberal, conservative, a Democrat or Republican, we have a common interest that is paramount to anything that divides us. You have got to have enough gumption to see that, you've got to have enough gumption to keep this ship afloat and when we see the ship is going to stay up then we'll have time for the folks to get together and settle the argument of who's going to be the captain, the chief mate, the crew, and what the fringe benefits are going to be.

Now that we have looked at the things we shouldn't do, what should we do? Well, the first thing they say is maybe a significant proportion of the physicians think that suggesting and amending can do a great deal to help this law. I don't know, I think that is political naivety. I'm sorry Dr. Todd, but it hasn't worked with Medicare, it hasn't worked with any other legislation where I have been involved.

The second alternative is recommending non-compliance. I am diametrically opposed to non-compliance. That is breaking the law, not complying with the Statutes and the terminology displeases me.

A third suggestion is non-participation. Now, this is not breaking the law. Nothing says that we have to participate. If we don't do it, they will get the Boy Scout mothers or someone else to do it. But this is better phraseology. In fact it is rather an effective counter move. Dr. Edwards, the PSRO Chief, has said that government is cognizant of the fact that they can't operate PSRO's without the fullest cooperation of the practicing physicians. Well, if they can't do it without us maybe this is the answer. However, other doctors have said, non-participation by organized medicine is an abrogation of our professional responsibility. The converse is true in my opinion. Participation by organized medicine is an abrogation of our professional responsibility.

The fourth route open to you is repeal. Well, you know it's a bad law, it's morally wrong. Georgia says that's the only ethical course to take and Dr. Todd has made the statement he is

of the opinion that the entire AMA Board of Trustees is in favor of repeal. You know in this country today there is a desperate need for more leadership; and I believe that physicians are in a unique position to provide that leadership. According to the polls we are still the most trusted and respected class in America of all the professionals. Farther up than the politicians, the attorneys, the school teachers, the ministers, the bankers. Well, you know if this is true, when and how do we proceed to meet all of these challenges that are inherent that we are facing today with PSRO and national health insurance.? I suggest that the when is now and that the how is by entering the arena of PSRO legislation—a subject about which we know more than anybody else. And so, at this hour, realizing the costs, realizing non-peer review, invasion of the right of privacy, devisiveness, wanting to clarify our position, and having been exposed to an extraordinary education of what the doctors in this State think, what the Congress thinks, and other officers in other states think, with all the energy I can muster and all the conviction I can convey, I am recommending that we do two things:

First, that we wage an all-out war for repeal of the PSRO law and two, while we are doing it we maintain a position of non-participation and we take nothing less.

Since the days of the Continental Congress, this country has been run by lawyers. Unfortunately, public confidence in the legal profession has dropped considerably because of alleged irresponsible acts and abuses by those men in higher places and partially because of misconceptions. But I will tell you one of the good things about the lawyers. They would never stand still for a moment for the creation of a bureaucratic body for professional standards review of their members or to inspect the confidential files of their clients, would they? We of medicine also are subjected to misconceptions. The high cost of seeing a physician, the maldistribution of the doctor; but when you think about maldistribution, did you ever drive through the ghetto? You don't see any grocery stores, filling stations, banks, medical care facilities—yet the hue and cry is to deride the physician. Nobody is critizing Winn-Dixie or Publix, but we must recognize that these misconceptions are present and they are growing. It is because of this that the government is preparing to implement PSRO legislation that is going to inflate the cost of medicine and decrease its efficiency. Today when we and our patients are threatened with a serious invasion of our privacy, when we are being stampeded over the cliff of socialized medicine, who should we expect to initiate the counter-action? I suggest that either we do it or it's not going to be done. There is not a man in this room, I believe, that would disagree with me that the most acceptable solution to PSRO would be repeal. There is not a man in this room who would disagree with me that we have a unique insight into the many unacceptable portions of the PSRO bill. So the plan is apparent, the battleground should be set. At this moment we should marshal our resources, set up our committees of correspondence, communicate to state associations, put causative pressure on Congress of the United States and draw our patients into this battle because it is their future at stake more than ours. We don't have to lecture to them in our offices; we can prepare statements explaining the fundamental pernicious effects of this legislation, and urge them if they want to pursue quality care of medicine in America and reserve the right of privacy, to communicate to their Congressmen they don't like PSRO. Other people have come up to me and said, "Joe, you can't expect Congress to repeal a law they just passed." Well, I tell you that's nonsense. Anything Congress does, they can undo, anything they have created, they can uncreate and I can tell you one thing—the argument that it's technically impossible is mere rationalization on the part of those that want to exploit the system or are too lazy and irresponsible to get involved and fight the PSRO legislation.

I can promise you one thing, and I have been in national legislation long enough to say this. With enough heat you can expect Congressmen to do anything. So all we have to do is communicate. In Georgia, nine of their ten Congressmen now are for repeal. Dr. Todd said that 59 have affixed their signature to this bill. That may be true, but there are more than 100 Congressmen in this United States who today would vote for repeal and you should realize that half the states of this Union have not tried to convince their Congressmen, and Florida is one, and if you will agree with me—with the leadership of Lou Murray, Sanford Mullen, Carl Andrews and others on the national legislative team, within one month, I will guarantee you, we can convince ten to thirteen of our fifteen Congressmen to add to that list.

People filled with fire and rage and indignation over what is happening to the world's last

hope have an obligation to stand up and be heard. We have an opportunity to win a fight they lost in Great Britain in 1948 and Sweden and Germany long before that. We stand to preserve the greatest medical care system this world has ever seen and in the process, maybe we can attack the opposition and start rolling back those other pernicious types of legislation affecting our lives. Perhaps we can establish a sense of community with the other people in the medical field and when we are being attacked, the dentists will join us, and when the dentists are being attacked maybe we will join them and maybe together we will join the businessman when outrageous allegations are made against him. These are the answers to the questions. We must recognize it as they realized it in 1776 when they said, "Together we stand, divided we fall." We must have better rapport and better coordination. We must recognize there is a peril afoot and they are going to take us piecemeal, one at a time. Individually we will be unable to resist this onslaught, but together we can do anything.

Remember, as Dr. Todd said, the pre-admission screening problem. In sixty days it turned around. We are the most powerful force in America today. We are more powerful than labor because we are respected: and we can't go to Washington everytime they hand us a regulation. We've got to go challenge the whole nine yards right now and quit our pussyfooting around.

In closing I would like to borrow a quotation from Patrick Henry when he was trying to inspire his colleagues in the Virginia House of Burgesses on the eve of Independence. He said, "If we wish to be free, if we wish to preserve those inviolate liberties for which we have been so long contending, we must basically not abandon this noble struggle in which we have been so long engaged and for which we pledged ourselves never to abandon, we must fight. I repeat, sir, we must fight."

Ladies and gentlemen, of the Florida Medical Association, if we wish to preserve those noble freedoms for which we have been so long struggling to preserve, we too, must fight and God willing, we shall prevail.

The smiles on the faces of the Von Thron family may indicate relief that the presidency of FMA and its burdens are soon to pass to another medical family. Because of the youthful look of the entire family, it is necessary to point out that Joseph C. Von Thron, M.D., is the gentleman at the right, and the lady in the center is Mrs. Von Thron. Others, left to right: son Jim; daughter Judy; and son John.

General Session

The General Session of the 100th Annual Meeting of the Florida Medical Association was called to order at 11:06 a.m. on Friday, May 10, 1974 in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, by President Joseph C. Von Thron, M.D.

Dr. Von Thron introduced the persons seated at the head table and gave special recognition to the Life Members of the Association. Dr. Robert C. Black of Orlando was recognized as being the oldest Life Member in attendance. Dr. Black is 94 years old.

Dr. Von Thron announced the winners of the awards for scientific exhibits.

1974 Scientific Exhibit Awards

FIRST PLACE: Fredric W. Pullen II, M.D. and Constance H. Cabeza, M.A., Miami: "Surgery for Dizziness"
SECOND PLACE: J. Brown Farrior, M.D. and James H. DePoyster, M.D., Tampa: "Tympanomastoidectomy in 3-D: Revisions and Causes of Failure"
THIRD PLACE: Robert B. Rhoades, M.D. and Richard Lockey, M.D., Gainesville: "The Imported Fire Ant: A Growing Problem for the Southern Allergist"
HONORABLE MENTION: Ian M. Reiss, M.D. and Melvin Levinson, M.D., South Miami: "Extracranial Cerebrovascular Disease"
Edward J. Riseborough, M.D. and James H. Herndon, M.D., Boston, Massachusetts: "Pathophysiology and Treatment of Fat Embolus"
James R. Jude, M.D., Irwin B. Boruchow, M.D. and Ramanuja Iyengar, M.D., Miami: "Indications for Cardiac Catheterization"

Dr. Von Thron recognized the following members of the Committee on Scientific Assemblies: Gerold L. Schiebler, M.D., Chairman; W. Dean Steward, M.D.; Calvin W. Martin, M.D.; Raul I. Lopez, M.D.; Bernard S. Linn, M.D.

Baldwin Lecturer Otis R. Bowen, M.D., Governor of Indiana, is congratulated on his address by FMA President Joseph C. Von Thron, M.D.

Mrs. Eugene G. Peek presented a check in the amount of $13,213.07 to the President of the Florida Medical Foundation, Dr. Von Thron, representing funds raised for the Foundation by the Woman's Auxiliary. Dr. Von Thron commended the ladies on the excellent work which they have done over the past year and gratefully acknowledged the check.

Dr. Von Thron extended special recognition to Mrs. Otis R. Bowen, President of the Woman's Auxiliary to the Indiana Medical Association, and to her husband, Honorable Otis R. Bowen, M.D., Governor of Indiana, who was invited to present the annual Baldwin Lecture.

Dr. Bowen reproved increasing governmental meddling in the affairs of the people and warned that with the advent of Professional Standards Review Organizations, more of the same looms in the future.

"We have had too many failures, or at best half successes, in the vast multitude of alphabet programs of the past," the Governor observed. "Yet our federal government continues to over-plan, to over-regulate and to over-run so much of our lives and so many of our businesses and professions."

Medicine, he continued, "has been the target and the recipient of more than its share of curtailment of its freedoms—and all in the guise of better care to more people at a cheaper price."

He predicted that PSRO's "will be one of the most divisive programs ever created: it will pit doctor against doctor, doctor against hospital and doctor against reviewing clerks."

Perhaps sensing the mood of his audience, Governor Bowen drew his strongest round of applause when he departed from his prepared text just long enough to call for repeal of PSRO legislation."

"I think that it should be repealed and I think it can be," he said.

In the future, he advised, physicians should be "increasingly aware—and understanding—of the causal motivations which give impetus to increasing involvement in health care delivery."

Dr. Von Thron adjourned the General Session at 11:50 a.m.

First House of Delegates

The First House of Delegates convened at 4:08 p.m. on Wednesday, May 8, 1974, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with Dr. Franklin J. Evans, Speaker of the House, presiding.

The invocation was given by Dr. Jack Q. Cleveland, Past President, of Coral Gables and the National Anthem was lead by Mrs. Jackie Harrison, 1st Vice President of the Woman's Auxiliary of the FMA.

The Past Presidents of the Woman's Auxiliary and the Past Presidents of the FMA were introduced individually and the membership on the Credentials Committee was announced.

Dr. Jerome Benson, Chairman of the Credentials Committee reported that a quorum of 168 delegates were present and that enough counties were represented to present a quorum. Dr. Benson moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—Henry J. Babers Jr., Stanley I. Cullen, David M. Drylie, Charles H. Gilliland, Gerold L. Schiebler (Absent—George H. Miller Jr.).

BAY—James D. Nixon (Absent—Owen Reese Jr.).

BREVARD—Lewis A. Bean, John T. Blackburn, James E. Carter, T. John Kaminski, Robert C. Seelman.

BROWARD—Andre S. Capi, James A. Jordan, William B. King, George P. Messenger, Jerry D. Moore, Ray E. Murphy Jr., F. B. Ott, Daniel C. Smith, W. D. Wells (Absent—Miles J. Bielek, R. B. Carson, M. P. Caster, R. S. Doyle, Fred G. Gieseke, David C. Lane, J. R. Mahoney, Henry D. Perry Jr., James B. Perry, Thomas F. Regan, Diran M. Seropian).

CAPITAL—Robert P. Johnson, N. H. Kraeft, Jack W. MacDonald, Robert N. Webster.

CHARLOTTE—Fred P. Swing (Absent—Melvyn J. Katzen).

CLAY—Laurin G. Smith III.

COLLIER—William J. Bailey, Fred A. Butler.

COLUMBIA—(Absent—Barnie L. Vanzant).

DADE—Pedro Arroyo, Jerome Benson, Morris Blau, Rufus K. Broadaway, Manuel Carbonell, Richard C. Clay, Jack Q. Cleveland, Vincent P. Corso, DeWitt C. Daughtry, O. William Davenport, Joseph Davis, Richard C. Dever, Robert Dickey, J. Lee Dockery, Charles Dunn, Joseph Fitzgerald, Ivor Fix, Richard M. Fleming, Pedro Greer, Marshall Hall, David Hallstrand, Joseph Harris, Walter Jones III, Maurice H. Laszlo, Rose London, Ronald Mann, Charles A. Monnin, Robert Schiess, Daniel Seckinger, Janice Sherwood, Everett Shocket, Ruth A. R. Simons, Chauncey M. Stone Jr., Mario Stone, William Straight, Robert E. Willner, Sheldon Zane (Absent—Rodrigo Bustamente, Sol Center, Sol Colsky, John E. Cunio, Edwardo Delgado, Rudolph Drosd, Norman Kenyon, Banning G. Lary, Carlos Llanes, Aaron Medow, Victor Politano, Walter W. Sackett Jr., Edward W. St. Mary, Lee Stapp, Gilbert Snyder).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL—Warren M. Barrett, James L. Borland Jr., Yank D. Coble Jr., Richard T. Donelan, Joe C. Ebbinghouse, Emmet F. Ferguson Jr., William J. Garoni Jr., Stephen P. Gyland, William T. Haeck, John C. Kruse, Sanford A. Mullen, John A. Rush (Absent—Charles B. McIntosh, Faris S. Monsour, Harry W. Reinstein Jr.).

ESCAMBIA—Charles J. Kahn, Philip B. Phillips, F. Norman Vickers, William M. C. Wilhoit, Henry M. Yonge.

FRANKLIN-GULF—Joseph P. Hendrix.

HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH—Frank C. Coleman, Richard G. Connar, Irving M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Richard S. Hodes, Victor H. Knight Jr., Joel W. Mattison, Thomas E. McKell, William W. Trice, Harold L. Williamson (Absent—Louis E. Cimino).

House Speaker Franklin J. Evans, M.D., Coral Gables, presides over the House at a time when John A. Rush Jr., M.D., Jacksonville (out of view), is giving the report of Reference Committee IV. At right at front table are Recorders Jerry Crosby and Sandy Neel.

INDIAN RIVER—James C. Robertson (Absent—Charles C. Flood).

LAKE—Thomas D. Weaver (Absent—Bergon F. Brokaw).

LEE—Larry P. Garrett, J. Stewart Hagen III, F. Lee Howington.

MADISON—(Absent—William J. Bibb).

MANATEE—John D. Lehman, Roger A. Meyer, M. P. Quillian.

MARION—H. L. Harrell, C. B. Henderson.

MARTIN—John Powers.

MONROE—John Buckner, Ronald H. Chase.

NASSAU—Marshall E. Groover.

OKALOOSA—William W. Thompson.

ORANGE—Norman F. Coulter, Francis M. Coy, William F. Eckbert Jr., Clarence M. Gilbert, Paul C. Harding, Joseph G. Matthews, Richard L. Parker Jr., James F. Richards Jr., Edward W. Stoner, Thomas B. Thames (Absent—G. Brock Magruder, Clifford L. Garrard).

OSCEOLA—George A. Gant.

PALM BEACH—William F. Ande, Carl E. Andrews, Vernon B. Astler, Curtis W. Cannon, Jerry F. Cox, George L. Ford Jr., J. Russell Forlaw, Bernard Kimmel, Richard B. Moore, Dick L. Van Eldik, Howard Willson.

PANHANDLE—H. E. Brooks.

PASCO-HERNANDO-CITRUS — W. Randall Jenkins (Absent—James P. Gills Jr.).

PINELLAS—Charles K. Donegan, Irwin L. Entel, James C. Fleming, John M. Hamilton, Daniel S. Hellman, David S. Hubbell, Roger A. Laughlin, Jack A. MaCris, Donald G. Nikolaus, David T. Overbey, Walter H. Winchester, Rowland E. Wood (Absent—Richard C. Trump).

POLK—Marvin G. Burdette, Thomas M. Caswall, J. G. Converse, Howard M. Dubose, John W. Glotfelty, W. E. Manry, Paul A. Tanner.

PUTNAM—(Absent—C. E. Barrineau).

ST. JOHNS—William W. O'Connell.

ST. LUCIE-OKEECHOBEE—H. C. McDermid.

SANTA ROSA—(Absent—William N. Watson).

SARASOTA—John N. Carlson, David A. Giordano, Franklin H. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.

SEMINOLE—(Absent—Luis M. Perez).

SUWANNEE-HAMILTON-LAFAYETTE — (Absent—Hugo F. Sotolongo).

TAYLOR—John H. Parker Jr.

VOLUSIA—Thomas W. Ayres, James A. Carratt, William H. Harrison Jr., Thomas L. Wells (Absent—Charles A. Stump).

WALTON—(Absent—Howard F. Currie).

SPEAKER OF THE HOUSE—Franklin J. Evans.

VICE SPEAKER OF THE HOUSE—Louis C. Murray.

Upon motion duly carried, the Rules and Order of Business of the House were adopted as follows:

Information for Delegates

The Rules and Order of Business for the House of Delegates is included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at *each meeting* of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Wherever possible, it is requested that resolutions and supplemental reports be forwarded to the Association's executive office by April 26 for duplication and distribution to the delegates.

All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairman to defer items in which they are interested in order that they may be present to discuss the subject.

A resolution before the Reference Committee must have a sponsor present before the Reference Committee. All resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be duplicated and available at the Reference Committee meetings when they convene. Only the 'resolved' portion of resolutions will be adopted as policy. Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House.

We also plan to have all Reference Committee reports duplicated and available to the delegates at the Registration Desk on the morning of the day the Second House of Delegates meets in the afternoon. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, as well as those which will be in the Delegates' Packets and the reports of the Reference Committees, have been color coded for easy reference. This color code is as follows:

REFERENCE COMMITTEE NO. I —Green
REFERENCE COMMITTEE NO. II —Buff
REFERENCE COMMITTEE NO. III—Blue
REFERENCE COMMITTEE NO. IV—Pink
REFERENCE COMMITTEE NO. V —Goldenrod

According to our By-Laws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented to the House, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Franklin J. Evans, Speaker
House of Delegates
Louis M. Murray, Vice Speaker
House of Delegates

The following correction was made in the Proceedings of the 1972 House of Delegates, as

published in the July 1973 issue of the Journal of the Florida Medical Association: In the Third House of Delegates, Elections of the President-Elect, Page 83, Dr. Moseley's nomination was seconded by Dr. Thomas McKell, Hillsborough County and not by Dr. David D. Hill.

A motion carried to approve the minutes of the 1973 House of Delegates as corrected.

The Speaker, Dr. Evans, advised that 71 members of the FMA have departed this life during the past year. In memory of these physicians roses have been placed in the vases at each end of the Speaker's podium. Dr. Evans asked that the House, out of respect and memory of these doctors who have passed on, rise in a moment of silent prayer.

Dr. Evans announced that a special congratulatory message for the centennial meeting had been received from one of the past presidents and his wife, Dr. and Mrs. Edward Jelks and that the roses had been contributed by Dr. Jelks.

The Speaker introduced the officers of the Association: Drs. Joseph C. Von Thron, President; Thad Moseley, President-Elect; Frederick C. Andrews, Vice President; William J. Dean, Immediate Past President; James W. Walker, Secretary and Treasurer; Louis C. Murray, Vice Speaker of the House; and Mr. W. Harold Parham, Executive Vice President.

The Speaker then instructed the House.

Remarks of the Speaker

President Von Thron, officers of the Association, Delegates and Alternate Delegates:

Once again, it is my pleasure to welcome you to this annual meeting of the House of Delegates and the Florida Medical Association. This welcome, however, has a special ring to it for this meeting is a very special one and is different from all the 99 other meetings held in the years gone by. It marks the 100th anniversary of our Association and a spirit of excitement and exhilaration pervades the atmosphere. Each individual associated with the Florida Medical Association is imbued with a feeling of pride and attainment. To some, this meeting has special significance, as it does to me. By a fortuitous circumstance, fate and your beneficence have cast me in the role of presiding officer on this eventful occasion, our centennial meeting. I am awed by the thought that it will be another hundred years before this momentous circumstance will be repeated. Just think, another century will have passed, long after each of us has departed from this earth, that a Speaker can proudly announce another centennial meeting.

In the midst of our commemoration and celebration, we must pause for a moment and reflect upon the purpose for which we of the House of Delegates have gathered here in this hall. Our By-laws decree that the House of Delegates shall meet annually to review and pass upon every piece of business of the FMA that has transpired since our last meeting one year ago, because the By-laws also designate the House of Delegates as the legislative, business and policy-making body of the Association. Thus, it is the duty and responsibility of this assembly to critically assess all the work of the past year done by our Board of Governors as well as our Commissions and Committees; all the resolutions introduced by county societies, specialty groups or individual members, all the proposed By-laws changes, etc. What is decided here shall become the policy and the philosophy of the FMA for the coming year.

I am sure that you are aware from the volume and complexity of the work recorded in your Handbook that it would be impossible to fulfill this mandate in the sessions remaining if the House were to act as a Committee of the Whole in discussing and debating each item of business. For this reason, as long ago as 1940, the Reference Committee format was adopted. As pointed out by Dr. William M. Straight in his brilliant chronicle on the history of the FMA in the centennial issue of the JFMA, "————up until 1940, the House transacted its business as a committee of the whole. However, the amount of business and its complexity increased to the point this method became cumbersome and of questionable effectiveness." And so the Reference Committee idea came into use.

The Reference Committees facilitate the work of the House of Delegates by conducting open hearings on all reports, resolutions, proposals, and any other items of business presented to the House of Delegates, and referred to these Committees. Members of the Association have the right and the privilege to be heard on any issue under consideration, and are urged to appear before these Committees to give the latter the benefit of their knowledge and expertise on a particular subject. So that when the Chairman of each Reference Committee reports the recommendations of his Committee to the House of Delegates at subsequent sessions, you will be assured that the recommendations represent the broadest cross-section of views of the membership as possible.

The time and meeting-place of each Reference Committee is published in your Handbook, as well as the reports and resolutions to be considered and debated. Please review these carefully and diligently and appear before a Reference Committee if you feel your comments or criticism will aid it in recommending the best course of action to be taken by the voting body. The final Reference Committee reports will be available to each Delegate before the second session of the House.

It is well to remind you that the Speaker and Vice Speaker are your officers elected by you to serve you. Our prime function and objective is to guide the deliberations of the body and facilitate the transaction of business in an orderly and harmonious manner in accordance with the rules of parliamentary procedure. Each member will be afforded the opportunity to free and full discussion of every proposition presented for decision, again within the bounds of parliamentary propriety. We will endeavor to use our authority fairly, wisely and discreetly, and will give heed to the will of the House.

Our Vice-Speaker, Dr. Murray, joins me in wishing each of you an exciting and fruitful meeting and in hoping that this will be the best meeting in 100 years.

Thank you.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

The Speaker then introduced the President, Dr. Joseph C. Von Thron.

Dr. Von Thron made a few remarks and then introduced the Brevard delegation, who, he said, made this all possible for him. The President introduced Mrs. Ray E. Murphy, Jr., President-Elect of the Woman's Auxiliary; Mrs. Ben S. Johnson, Southern Regional Vice President to the Woman's Auxiliary of the AMA; and Mrs. Hugh Mathews, President of the FMA Woman's Auxiliary.

Dr. Evans, the Speaker, introduced the President-Elect of the American Medical Association, Dr. Malcolm C. Todd, and asked him to come to the podium for a special presentation.

Dr. Todd congratulated the FMA on its centennial and commented on the fine accomplishments of Dr. Jere Annis who is a member of the AMA Board of Trustees. He also stated that special commendation should go to a number of the men on the Florida Delegation that have worked for many years on behalf of the Florida Medical Association. He suggested that each member of the House should do his part to support the election of Dr. Richard Connar to the AMA Council on Medical Education.

Dr. Todd further stated that the best quality of medical care practiced anywhere in the world is practiced in the United States of America. He indicated that there is no health crisis in this country but that there are problems relating to the various pieces of legislation which have been introduced which will affect the private practice of medicine. Dr. Todd indicated that the Board of Trustees is doing everything in its power to combat this legislation. He also forewarned the House that a very damaging article will appear in the Medical World News which is to be released on May 10 and suggested that everyone read the article but not believe everything that is read. He stated that the Board of Trustees of the AMA is working in concert with one another, they are cooperating and have excellent contact with the state medical societies, and trying to respond to the wishes and desires of the membership.

Dr. Todd pleaded for continued unity among the profession, stating that the AMA represents all the physicians. He urged that each physician raise his fees in accordance with his increased costs and rely on increased production to raise his income. Dr. Todd commented on the various issues pertaining to National Health Insurance and concluded his talk by congratulating the Woman's Auxiliary on the outstanding works they have accomplished.

Dr. Todd presented to Dr. Von Thron a plaque from the American Medical Association to the Florida Medical Association in commemoration of the dedicated physicians who have guided the Florida Medical Association to its 100th anniversary with an outstanding record of improving the public health and practice of medicine in the State of Florida.

The President, Dr. Von Thron, introduced Mr. Whalen M. Strobhar, Director of the Public Affairs Division, American Medical Association; Mr. Jack Herbert, President, Blue Shield of Florida; Mr. Joe Stansell, Senior Vice President, Blue Shield of Florida; Dr. Edmund F. Ackell, Vice President of Health Affairs, University of Florida; and Dr. Wilson T. Sowder, Director of the Division of Health, Dr. Sowder received a standing ovation in expression of gratitude for his many accomplishments over the past years on behalf of Florida medicine.

Dr. Von Thron introduced his secretary, Mrs. Rosemary Geisman; his mother-in-law, Mrs. Taylor; his mother, Mrs. Von Thron; his wife, Jane, and three of his children, John, Judy, and Joan.

The Speaker, Dr. Evans, assumed the chair to introduce the President of the Florida Dental Association, Leslie Bell, D.D.S.

Dr. Bell, in a few remarks to the House of Delegates, urged that the Florida Medical Association and the Florida Dental Association continue to work together for a unified goal. Dr. Bell presented a gavel to Dr. Von Thron from the Florida Dental Association in commemoration of this historical occasion.

Dr. Von Thron then presented his annual address.

The Speaker announced that the meeting times of the Reference Committees and the Reference Committee personnel are published in the handbook. Dr. Evans announced the Chairmen of the Reference Committees, the AMA delegates assigned to each one as advisors, and the time and place of each meeting:

Reference Committee No. I—Health and Education
10:00 a.m., Regency Room South
Richard M. Fleming, Chairman
Rufus K. Broadaway, AMA Delegate Advisor

Reference Committee No. II—Public Policy
10:30 a.m., Congress Room
Andre S. Capi, Chairman
Richard G. Connar, AMA Delegate Advisor

Reference Committee No. III—Finance and Administration
11:00 a.m., Regency Room North
Dewitt C. Daughtry, Chairman
Samuel M. Day, AMA Delegate Advisor

Reference Committee No. IV—Legislation and Miscellaneous
10:30 a.m., Regency Room East
John A. Rush Jr., Chairman
Burns A. Dobbins Jr., AMA Delegate Advisor

Reference Committee V—Medical Economics
10:00 a.m., Regency Room West
John C. Fletcher, Chairman
Robert E. Zellner, AMA Delegate Advisor

The Vice Speaker, Dr. Murray, advised that if there was no objection reports and resolutions would be assigned as published in the Handbook. No objection was raised. The House's attention was called to the referrals of supplemental reports and resolutions which had been distributed in the Delegates' packets.

The Speaker, Dr. Evans read the following telegram which had just been received:

"Jere W. Annis, M.D., Trustee, AMA, received the Distinguished Internist of the Year Award from the American Society of Internal Medicine during the 18th Annual Meeting in San Francisco, May 2-3."

Dr. Evans asked if there were any additional reports from the floor. There were none.

The Speaker announced the Blue Shield Annual Meeting to be held Thursday, May 9, in the Regency Room North at 8:00 a.m. and the AMA Delegates Reference Committee, 9:00 a.m., Friday, May 10 in the Tack Room.

It was announced that Masters & Johnson would make a presentation at 5:30 p.m., Thursday, May 9 in the Regency Room North and the Florida Physicians Association Officers and Board of Directors are meeting in the Secretariat Room immediately following recess of the 1st House of Delegates. The Annual General Membership Meeting of the Florida Physicians Association will begin at 4:00 p.m. on Thursday, May 9, in the Congress Room.

The Speaker advised the House that a Joint FLAMPAC and Woman's Auxiliary Luncheon will be held Friday, May 10, at 12:15 p.m. in the Les Ambassadeurs Dining Room. Guest Speaker for this luncheon will be former Miss America, Marilyn Van Derbur Atler.

It was announced that the President's Prayer Breakfast will be at 7:30 a.m., Sunday, in the Cafe Cristal and the General Session will be Friday, May 10 at 11:00 a.m., Regency Room North. The Hon. Otis R. Bowen, M.D., Governor of Indiana, will present the Baldwin Lecture.

Dr. Robert E. Zellner announced that the Blue Shield Board meets immediately following this 1st House in the same room.

Dr. Evans asked all Reference Committee personnel to meet with their respective Chairmen immediately following this meeting.

The First House of Delegates recessed at 6:00 p.m., to reconvene on Saturday, May 11 at 3:00 p.m.

These gentlemen are past presidents of FMA, and they got together during the Centennial Meeting to talk over old times. Front row (right to left): George S. Palmer, M.D., Tallahassee (1966); Robert E. Zellner, M.D., Orlando (1962); Jere W. Annis, M.D., Lakeland (1958); Duncan T. McEwan, M.D., Orlando (1954); Walter C. Jones, M.D., Miami (1941); William C. Roberts, M.D., Panama City (1957); Ralph W. Jack, M.D., Miami (1959); and Warren W. Quillian, M.D., Coral Gables (1963). Back Row: H. Phillip Hampton, M.D., Tampa (1965); Samuel M. Day, M.D., Jacksonville (1964); Leo M. Wachtel, M.D., Jacksonville (1960); Henry J. Babers, M.D., Gainesville (1969); W. Dean Steward, M.D., Orlando (1967); Jack Q. Cleveland, M.D., Coral Gables (1968); William J. Dean, M.D., St. Petersburg (1972); James T. Cook, M.D., Marianna (1970); and Floyd K. Hurt, M.D., Jacksonville (1971).

Second House of Delegates

The second meeting of the House of Delegates convened at 3:08 p.m., Saturday, May 11, 1974, in the Regency Room North of the Diplomat Hotel, Hollywood, with Dr. Franklin J. Evans, Speaker of the House, presiding.

Dr. Evans, the Speaker, opened the meeting with the remark that it was his wish that this would be the best meeting that FMA has had for 100 years, and it appeared that his wishes were coming true. Dr. Evans stated that he felt that the Executive Vice President was mostly responsible for this. Mr. Parham received a round of applause.

Dr. Jerome Benson, Chairman of the Credentials Committee reported that 192 delegates were present, constituting a quorum and that more than half of the counties were represented. Dr. Benson moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—David M. Drylie, Charles H. Gilliland, George H. Miller, Gerold L. Schiebler (Absent—Henry J. Babers Jr., Stanley I. Cullen).

BAY—Owen Reese Jr. (Absent—James D. Nixon).

BREVARD—Lewis A. Bean, John T. Blackburn, James E. Carter, T. John Kaminski, Robert C. Seelman.

BROWARD—Robert J. Brennan, Andre S. Capi, M. P. Caster, Fred G. Gieseke, T. W. Hahn, James A. Jordan, David C. Lane, George P. Messenger, Jerry D. Moore, Ray E. Murphy Jr., F. B. Ott, Henry D. Perry Jr., James B. Perry, Thomas F. Regan, Diran M. Seropian, N. J. Skaja, Daniel C. Smith, W. D. Wells (Absent—R. B. Carson, William B. King).

CAPITAL—Robert P. Johnson, N. H. Kraeft, Jack W. MacDonald, Robert N. Webster.

CHARLOTTE—Melvyn J. Katzen, Fred P. Swing.

CLAY—Laurin G. Smith III.

COLLIER—William J. Bailey, Fred A. Butler.

COLUMBIA—(Absent—Barnie L. Vanzant).

DADE—Pedro Arroyo, William Aten, Jerome Benson, Morris Blau, Rufus K. Broadaway, Manuel Carbonell, Sol Center, Richard C. Clay, Jack Q. Cleveland, Vincent P. Corso, DeWitt C. Daughtry, O. William Davenport, Joseph Davis, Richard C. Dever, Robert Dickey, J. Lee Dockery, Charles Dunn, Miguel Figueroa, Joseph Fitzgerald, Ivor Fix, Richard M. Fleming, Pedro Greer, Julian Groff, Marshall Hall, David Hallstrand, Henry Hardin, Joseph Harris, James Hutson, Walter Jones III, Banning G. Lary, Maurice H. Laszlo, Carlos Llanes, Rose London, Ronald Mann, Charles A. Monnin, Ed Preston, Walter W. Sackett Jr., Edward W. St. Mary, Robert Schiess, Daniel Seckinger, Janice Sherwood, Everett Shocket, Ruth A. R. Simons, Chauncey M. Stone Jr., Mario Stone, William Straight, Stanley Wharton, Robert E. Willner, Art Wood, Sheldon Zane (Absent—John E. Cunio, Rudolph Drosd).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL—Warren M. Barrett, Yank D. Coble Jr., Joe C. Ebbinghouse, Emmet F. Ferguson Jr., William J. Gaboni Jr., Stephen P. Gyland, William T. Haeck, Donald R. Hagel, John C. Kruse, Charles B. McIntosh, Faris S. Monsour, Sanford A. Mullen, John A. Rush Jr. (Absent—James L. Borland Jr., Richard T. Donelan).

ESCAMBIA—Charles J. Kahn, Philip B. Phillips, F. Norman Vickers, William M. C. Wilhoit, Henry M. Yonge.

FRANKLIN-GULF—(Absent—Joseph P. Hendrix).

HIGHLANDS—(Absent—Donald C. Hartwell).

HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Irving M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Victor H. Knight Jr., Joel W. Mattison, Harold L. Williamson (Absent—Richard G. Connar, Richard S. Hodes, Thomas E. McKell, William W. Trice).

INDIAN RIVER—James C. Robertson, Paul W. Taylor.

LAKE—Bergon F. Brokaw, Thomas D. Weaver.

LEE—Larry P. Garrett, J. Stewart Hagen III, F. Lee Howington.

MADISON—(Absent—William J. Bibb).

MANATEE—John D. Lehman, Roger A. Meyer (Absent—M. P. Quillian).

MARION—H. L. Harrell, C. B. Henderson.

MARTIN—(Absent—John Powers).

MONROE—John Buckner, Ronald H. Chase.

NASSAU—Marshall E. Groover.

OKALOOSA—William W. Thompson.

ORANGE—Norman F. Coulter, Francis M. Coy, William F. Eckbert Jr., Clarence M. Gilbert, Paul C. Harding, G. Brock Magruder, Joseph G. Matthews, Richard L. Parker Jr., James F. Richards Jr., Edward W. Stoner, Thomas B. Thames, Robert B. Trumbo.

OSCEOLA—George A. Gant.

PALM BEACH—Willard F. Ande, Carl E. Andrews, Vernon B. Astler, Curtis W. Cannon, Jerry F. Cox, George L. Ford Jr., J. Russell Forlaw, Bernard Kimmel, Richard B. Moore, Dick Van Eldik, Howard Willson.

PANHANDLE—H. E. Brooks.

PASCO-HERNANDO-CITRUS — W. Randall Jenkins (Absent—James P. Gills Jr.).

PINELLAS—Charles K. Donegan, Irwin L. Entel, James C. Fleming, John M. Hamilton, Daniel S. Hellman, David S. Hubbell, Roger A. Laughlin, Jack A. MaCris, Donald G. Nikolaus, David T. Overbey, Richard C. Trump, Walter H. Winchester, Rowland E. Wood.

POLK—Marvin G. Burdette, Thomas M. Caswall, J. G. Converse, Howard M. Dubose, John W. Glotfelty, W. E. Manry, Paul A. Tanner.

PUTNAM—C. E. Barrineau.

ST. JOHNS—William W. O'Connell.

ST. LUCIE-OKEECHOBEE—H. C. McDermid.

SANTA ROSA—(Absent—William N. Watson).

SARASOTA—John N. Carlson, David A. Giordano, Franklin H. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.

SEMINOLE—Luis M. Perez.

SUWANNEE-HAMILTON-LAFAYETTE—Hugo F. Sotolongo.

TAYLOR—(Absent—J. H. Parker Jr.).

VOLUSIA—Thomas W. Ayres, James A. Carratt, William H. Harrison Jr., Charles A. Stump, Thomas L. Wells.

WALTON—(Absent—Howard F. Currie).

SPEAKER OF THE HOUSE—Franklin J. Evans.

VICE SPEAKER OF THE HOUSE—Louis C. Murray.

Dr. Evans, the Speaker, stated that since this was a very special, unique year, he would like to recognize some of the individuals who have worked hard in the past years.

Special recognition was given as each member of the Board of Governors, the Editor of the Journal, the Council Chairmen, County Medical Society Presidents, and AMA Delegates and Alternates were introduced individually and commended for the fine work they have done.

Senator Bruce Smathers of Jacksonville, a special guest of the Association, was introduced.

The President, Dr. Von Thron, introduced Mrs. Donald R. Hagel, Chairman, Woman's Auxiliary, AMA-ERF Committee, and Mrs. Hugh Mathews, President, Woman's Auxiliary who presented to the medical school deans unrestricted contributions from the AMA-ERF. Dr. Von Thron asked the Deans to come forward.

Dr. Chandler A. Stetson, Dean, accepted the contribution for the University of Florida College of Medicine in the amount of $8,743.53. Dr. Donn L. Smith, M.D., Dean, University of South Florida College of Medicine, accepted the contribution of $8,253.36 for his University. A check for $7,844.25 was presented to Dr. Bernard J. Fogel, Dean, University of Miami School of Medicine. $316.53 will also go to the Florida State University Basic Sciences.

Dr. Von Thron, after a few remarks, asked the Deans to return to the podium. Dr. Edmund F. Ackell, Vice President of Health Affairs, University of Florida, was asked to come to the podium.

Dr. Ackell: "On this the 100th anniversary of the Florida Medical Association it is fitting that we recognize another milestone which has been reached at this meeting. There are many ways which people receive honors for faithful and dedicated service. A university such as our University of Florida rewards such individuals by granting an honorary degree to a few people annually in recognition for service to society and to their profession.

"Over the past few years many members of the Florida Medical Association including past presidents and your present president, have mentioned to me and extolled the diligent efforts of one individual whom we will honor today.

"I should also mention that this is the first time in the history of the University of Florida that a convocation for granting an honorary degree has been held off campus. Because of the significance of this centennial convention, it is fitting that this honorary degree be presented before the people that this individual has served for 25 years.

"On this occasion it is a great privilege for the Florida Medical Association and the University of Florida to dedicate a few moments to awarding an honorary degree to one of your favorite sons.

"Assisting me will be Assistant Vice President for Health Affairs, Dr. Bernie Fogel, College of Medicine, University of Miami; Dr. Donn Smith, Dean and Director of the Medical Center, College of Medicine, University of South Florida; Dr. Chandler Stetson, Dean of the College of Medicine at the University of Florida; Dr. Jere Annis, Chairman of the Advisory Committee, College of Medicine, University of Florida."

Dr. Stetson: "Mr. Vice President, I present William Harold Parham for the honorary degree of Doctor of Health Administration. An alumnus of the University of Florida and Stetson University, Mr. Parham has spent his entire career in the health profession. In 1949 he became Supervisor for Public Relations at the Florida Medical Association and has served that Association with distinction for the past 25 years. Two Florida Governors have appointed him to committees on health. He has served as a member of the Florida Health Advisory Council and is a member of its Executive Committee. He has served as Director of the Florida Regional Medical Program and as its Secretary/Treasurer; he has been a member of the Public Relations Advisory Committee of the American Medical Association and a member of the American Association of Medical Society Executives which elected him its President in 1968.

"His many responsibilities have included liaison work with local and state governments, with voluntary health agencies, and with Florida's universities and he has always discharged these responsibilities in a courageous, dedicated, creative, and highly effective manner. I present him so that the University of Florida may recognize his many achievements in the field of health and his quarter century of devoted service to the profession of medicine."

Dr. Ackell: "William Harold Parham, the depth and breadth of your responsibilities have enabled you to make an outstanding contribution to the profession of medicine. Your leadership has been of the highest order and the University of Florida is pleased to recognize your distin-

guished contributions in public health. On behalf of President E. T. York and the authority vested in him by the Board of Regents, I hereby confer upon you the degree of Doctor of Health Administration together with all the rights, privileges, and emoluments thereto pertaining. Congratulations."

Dr. Parham: "Thank you very much."

Dr. Parham received a standing ovation from the House.

Dr. Parham: "I can't say too much, I am a little bit emotional and totally surprised, to put it mildly. I would like to take the opportunity, however, to thank the many physicians who have given of their time and energies on behalf of this Association which made it possible for me to accomplish anything. On the other side, the members of the staff that have been with us for many, many years, who worked to make me look good and to help us accomplish the job, I thank you from the bottom of my heart and I thank the University of Florida also."

Dr. Von Thron requested that Dr. Parham's children, Mary Virginia and Will to accompany Mrs. Parham to the podium for introduction.

The Speaker, Dr. Evans assumed the chair to introduce Dr. Richard Hodes, Dr. Eugene Tubbs, and Dr. Walter Sackett of the Florida House of Representatives.

Report of Reference Committee No. 1
Health and Education

Dr. Richard M. Fleming, Chairman of Reference Committee No. 1, and all the members of his committee came forward to present the report of the committee.

Council on Scientific Activities

The Reference Committee proposed the following amendments to the report of the Council on Scientific Activities.

After study of the report of the Committee on Continuing Medical Education, and in accordance with the actions of the Board of Governors in March, 1974, the Reference Committee recommended that the last sentence of the third paragraph of the report of the Committee on Continuing Medical Education be deleted.

The recommendation to amend the Committee on Continuing Medical Education report was adopted.

Upon recommendation of the Reference Committee the report of the Committee on Medical Students was filed.

The report of the Council on Scientific Activities was adopted as amended.

This is Reference Committee I, which considered reports and resolutions on health and education submitted to the House of Delegates. Left to right: Maurice H. Laszlo, M.D., North Miami Beach; William H. Harrison Jr., M.D., Daytona Beach; Richard M. Fleming, M.D., Miami, Chairman; Recorder Marcia Protheroe; Donald G. Nikolaus M.D., Dunedin, F. Norman Vickers, M.D., Pensacola; and Rufus K. Broadaway, M.D., Miami, AMA Delegate.

Council on Scientific Activities

GEROLD L. SCHIEBLER, M.D., *Chairman*

During the Association's 1973-74 year, the Council on Scientific Activities held meetings on December 8, 1973, and March 9, 1974. The past year saw a continuing refinement of the committees' structures and programs. The Council concerned itself with a variety of activities including reviewing the initial implementation of the continuing medical education program, and the projected reorganization of the Committee on Medical Schools and Scientific Publications.

Each committee's activities for the year will be summarized in this consolidated Council report. Several recommendations of the Council and its committees were previously submitted to, and acted upon, by the Executive Committee and the Board of Governors and will appear in the report of the latter body. Recent recommendations adopted by the Council at its March 9, 1974 meeting will be filed as a supplemental report.

The Committee on Continuing Medical Education concentrated its efforts on implementing the various aspects of the continuing medical education program. One such effort was the development of a "Central Registry" of continuing medical education opportunities for physicians in Florida. The "Central Registry" will be maintained at FMA Headquarters and will allow for storing and retrieving information regarding CME programs according to the scheduled month and year, locality, AMA category headings, and by specialty groups. In relation to the "Central Registry," the Committee is pleased to report that the "Florida Compact for Continuing Medical Education of Physicians" was sent out to fifty-two agencies and organizations who upon signature will coordinate their CME program through the "Central Registry." In another action the Committee revised the "Request for Approval or Co-sponsorship of Postgraduate Medical Education by the Florida Medical Association" form. The revised form eliminates the category of "sponsorship" and adds a category covering the amount and purpose of registration fees. Information of this type will also be available through the "Central Registry."

The Committee reviewed a request from the Honorable O. J. Keller, Secretary, Department of Health and Rehabilitative Services, State of Florida, asking that one or two physicians, working full-time for the Department, be placed on the Committee. In answer to that request, the Committee recommended that the new HRS Medical Coordinator be asked to serve as a consultant to the Committee on Continuing Medical Education. In addition, the Council Chairman, who is an ex-officio-member, of this Committee is presently one of Secretary Keller's Division Directors and should provide the needed liaison between HRS and this Committee of the FMA.

The Committee put considerable time and effort into reviewing the "Mechanism for Certifying Hours of Continuing Medical Education" as passed, in principle, by the Board of Governors in October 1973. It was the consensus of the Committee that many of the county medical societies will find it difficult to handle the certification process of members' CME credits. Concern was expressed that if the Association did not do an adequate job in the certification of credits, then either the state or federal government might step in and regulate the program. The Committee expressed the need to have a continuing medical education program that will be standardized and administered in the same way throughout the state. Considerable discussion revolved about computerization of the program. However, the Committee concluded that before funds were spent for computerization a program should be enacted in which a system for implementation could be tried, refined, perfected, and administered by the FMA Executive Office.

At the February 28, 1974, meeting of the Committee, the AMA Council on Medical Education's policy of strongly encouraging state medical societies to set up their own accreditation program for community hospital and other local organizations in the field of continuing medical education programs was considered. It was concluded that such an accreditation program in Florida would permit physicians to secure top quality CME at their own hospitals. The Committee also noted that other states that have entered into an accreditation program have done so without adding to the budget by charging institutions and organizations a fee to cover the overhead and expenses. The Committee has recommended to the Council that it be given authority to develop plans for such an accreditation program.

The Committee on Medical Schools established an effective working relationship with the Board of Regents of the State University System. Over the past several years, there have been numerous attempts to have either the Committee on Medical Schools, or the Florida Joint Commission on Medical Education, designated as the medical advisory body to the Board of Regents. However, it was not until this year that an official request to the FMA was made by the Chairman of the Board of Regents for a medical advisory committee that could respond to specific requests for advice and initiate recommendations regarding medical matters. Such advice would be channeled through the Vice Chancellor for Medical and Health Sciences, Dr. Kenneth Penrod, and through the Chancellor of the SUS, Dr. Robert Mautz. This would be passed on to the Board of Regents unedited.

In order to provide the Board of Regents with the most meaningful advisory body, the Committee reviewed the establishment, history and functions of the Committee on Medical Schools and Florida Joint Commission on Medical Education. It concluded that considerable confusion existed over the relative roles of these two bodies. The conclusion of the Committee was to recommend that a new committee (Committee on Medical Education) be established which will incorporate the current functions of the Committee on Medical Schools and most of the functions of the Florida Joint Commission on Medical Education. If this recommendation is approved by the Board of Governors and the House of Delegates then the Committee on Medical Schools and the Florida Joint Commission on Medical Education would be dissolved.

The Committee, at the request of the Vice Chancellor for Medical and Health Sciences of the Board of Regents, considered the question of the need for a school of osteopathic medicine and a school of optometry in Florida. The Committee advised the Vice Chancellor that there is no demonstrated need for a separate school of optometry at the present time, and if the need for training such individuals in Florida can be justified in the future, such training would be carried out more economically by utilizing the existing educational programs in ophthalmology. In regard to a school of osteopathic medicine, the Vice Chancellor was informed that such a need should be considered on a cost benefit basis and additional state funding for training in primary care medicine should be expended through existing educational programs.

The Committee reviewed the problems faced by the medical schools in regard to the recent amendment to the Florida Medical Practice Act which provides for automatic expiration of the Faculty Teaching Certificate after one year. The medical schools reported instances in which highly recognized and qualified faculty members were unable to pass the licensure examination within one year. The Committee agreed to support the medical schools by recommending to the Council and the Board of Governors that under certain conditions licensure under the Faculty Teaching Certificate could be extended for an additional two years.

The Committee is pleased to report that the Board of Regents has recently established a Standing Committee for Health Affairs. The purpose of this Committee is to review and recommend to the Board of Regents policies affecting health programs of the state university system, with particular concern for the medical education programs at the University of Florida and University of South Florida. The Committee for Health Affairs has obtained approval for an advisory committee whose

members will include the Executive Committee of the proposed new "Committee on Medical Education."

The Committee has also been involved in working with the staff of the Florida House Committee on Education chaired by Representative Bill Conway in an attempt to assist it in recognizing areas of need pertaining to health education.

The Committee on Regional Medical Program kept the Council advised of Florida Regional Medical Program activities. As a result of limited and insecure Federal funding of the program, initially there was only limited activity. More recently, monies allocated to the RMP program have been released and various health projects are being funded. The Council at its March 9th meeting made several specific recommendations in regard to the RMP program which will be included in the supplemental report of this Council.

The Committee on Research continued its function as a review and evaluating group for the Florida Medical Foundation. Medical research grant applications from physicians in Florida are sent to the Foundation requesting funds for a specific project.

The Foundation had returned to it the unused portion of a 1971 grant. Therefore, it began the year with a balance considerably larger than that which had been available in past years.

The Committee received grant requests from ten (10) applicants. Five of these were rejected because their financial requirements exceeded the amount available. Another was rejected because the project did not fit the criteria. At the time of this report, the four residual requests remain under consideration. Because of the long time involved since the initial application, the Committee is asking for a statement from each of the remaining four applicants relative to their current financial requirements. After these are received the Committee will make a final recommendation. The Committee plans to meet in May 1974.

At the request of the Board of Governors, the Committee developed a "check list of criteria." This "check list" was approved by the Council and the Board of Governors and is now operational. It provides the Committee with a mechanism to record in a systematic manner a professional evaluation of all grant applications.

The Committee on Scientific Assemblies is proud to report that there will be a number of special features at the 1974 annual meeting due to this being the FMA centennial celebration. These include a plenary session on Antibiotics and Infectious Disease and a special program for physicians and their wives by Masters and Johnson. The format continues to be the same as in previous years in which state specialty societies co-sponsor, plan and produce the scientific programs. This year's program as completed includes 24 scientific sections and 23 exhibits.

In the past, some groups have objected to the placing of individual names on exhibits presented by specialty societies, FMA councils or committees. The Committee suggested that only names of the sponsoring state specialty society, FMA council or committee appear on the scientific or educational exhibits that fall in this category, with the proviso that these exhibits not be eligible for an award. This concept was approved by the Council and the Board of Governors.

The Committee on Scientific Publications had its high point of the year when the Centennial Issue of *The Journal of the Florida Medical Association* rolled off the presses.

Long in preparation and planning, and representing many hours of work on the part of the editors and contributors, the Centennial Issue is a document of which all members of the Florida Medical Association can be proud. Your Committee is gratified by the many unsolicited compliments that this issue attracted.

A special tribute is due to the Historical Editor, William M. Straight, M.D., whose affinity and knowledge of Florida's rich medical history guided the project from conception to delivery.

Notwithstanding the Centennial Issue, *The Journal* has had its problems. Rising paper and printing costs, coupled with decline in national pharmaceutical advertising, have forced the publication into a financial squeeze. Your Committee is doing everything possible to hold costs down and maintain the quality of *The Journal.*

In the future, your Committee expects to explore ways to attract new advertisers to take up some of the slack left by withdrawal of some pharmaceutical houses from the state medical journal advertising field.

The Committee has planned one special issue in the coming months, an issue on Ethics and Discipline. This will be a collection of papers presented at a series of regional half-day conferences sponsored jointly by the Judicial Council and the Florida Board of Medical Examiners. Plans are being made to resume the historical issue next August as published annually for the past several years.

Several other new features for *The Journal* are under consideration. One is a monthly digest of general medical news that would be bound with the scientific pages.

Finally, this Committee has conceived and recommended a plan for its own reorganization. Because amendments to the FMA By-Laws are involved, action by the House of Delegates is necessary. This re-organization has been approved by the Council and submitted to the Board of Governors.

Briefly, the plan envisions a nine-member Committee on Scientific Publications, with three members being appointed by the Board of Governors each year for three-year terms. One member of the Committee would serve as Editor, one as Associate Editor and the other seven as Assistant Editors. One member of the faculty of each of the three medical schools in Florida would be on the Committee at all times.

Supplemental Report
Council on Scientific Activities

The Supplemental Report of the Council on Scientific Activities was adopted as presented.

Supplemental Report
Council on Scientific Activities

GEROLD L. SCHIEBLER, M.D., *Chairman*

The Council on Scientific Activities, at its March 9, 1974 meeting, reviewed and made recommendations on many items presented by the committees. This supplemental report will briefly highlight, by committee, the actions taken by the Council.

The Committee on Continuing Medical Education: The Council unanimously supported this Committee's request to the Board of Governors to have the FMA formally invite the Florida Osteopathic Medical Association to join with the FMA and other proposed groups as a participant in the "Florida Compact for Continuing Medical Education."

In another action the Council unanimously recommended to the Board of Governors that the FMA implement "System II" for the purpose of providing a more uniform state-wide continuing medical education program, with a centralized administration. Intrinsic to "System II" remains the cardinal principle that each county society will retain the responsibility for the verification of each member's CME credits.

In still another action, the Council voted, by a bare majority, to recommend to the Board of Governors that they accept, through the Florida Medical Foundation, a Community Hospital Education Council Grant of $20,000. The Council on Scientific Activities was careful to specifically recommend that these monies should be used by the Committee primarily for nonrecurring costs in the development of a state-wide CME program, and that such an acceptance would be on a "once only" basis.

The Council unanimously recommended to the Board of Governors that the Committee be authorized to develop at state-wide plan relating to the accreditation of CME programs which do not have automatic direct review by the AMA. Such programs would be evaluated *only* upon the request of the sponsoring group or institution, and they would be primarily programs developed and offered in local areas. After approval by the Board of Governors, the Committee will develop such a plan of accreditation. It would then be formally presented to the Council and Board of Governors for review and approval prior to implementation.

The Council unanimously recommended to the Board of Governors that they consider a resolution requesting the House of Delegates to implement a six months delay in the initiation of the FMA continuing medical education requirements. This decision was based on the evaluation of present logistical problems, coupled with the need for a continuing effective state-wide information campaign relating to CME.

The Committee on Medical Schools: The Council unanimously supported a request to have the title of "Executive Committee" of the proposed new "Committee on Medical Education" changed to "Steering Committee" and that the membership of the "Steering Committee" be increased to five members in order to add a representative from the FMA Executive Committee.

The Committee on Regional Medical Program: The Council unanimously supported the concept of recommending to the Board of Governors that they request the Florida Regional Medical Program (FRMP, Inc.) to increase the size of their Executive Committee (from 5 to 6) in order to allow representation by either the Chairman of the FMA Committee on Regional Medical Program, or a member of the FMA Executive Staff. It was felt by the Council that such action on the part of FRMP, Inc. would tend to bring about optimal communication between the FMA and FRMP, Inc.

The Council also restated a previous request, (1972) that the Board of Governors urge the Florida Regional Medical Program (FRMP, Inc.) to separate the office of State Chairman and President.

The Council unanimously supported the petition of the Chairman of the FMA Committee on Regional Medical Program to request the Board of Governors to reassess the relationship between the FMA and FRMP, Inc. and to give advice and direction to the FMA Committee on Regional Medical Program and to the Council regarding its present and future FMA-FRMP, Inc. programmatic linkages.

The Committee on Scientific Assemblies requested the Council to review the question of having an osteopath deliver a scientific paper at the annual FMA meeting in a Scientific Section. The Council (by a vote of 5 to 1) petitioned the Board of Governors to formulate a policy concerning the 1971 resolution of the House of Delegates regarding the participation of osteopaths in scientific activities, beyond that of being a guest of an FMA member. Also, the Council interpreted the action of the House of Delegates to mean that osteopaths could not deliver papers of scientific sections, and thus should not be allowed to appear on the formal printed program. The Council voted to support whatever decision was made by the Board of Governors in the particular item under discussion. The Council also requested permission to study the entire matter regarding participation of osteopaths in the scientific activities of the FMA, particularly since some osteopaths are being educated, or have been trained in AMA approved post-graduate training programs. Such individuals could become board-eligible or board-certified in their specialty.

The Committee on Scientific Publications: The Council voted unanimously to ask the Board of Governors to consider the petition of Dr. Clyde Collins, Chairman of the Committee on Scientific Publications, to approach the Woman's Auxiliary of the FMA and request their aid in developing advertising revenue from local sources in order to increase the funding base of the FMA Journal.

In supporting this request, the Council recognized and supported the concept that the Woman's Auxiliary should not be exposed to multiple requests from many different sources within the FMA structure. However, rising production costs and decreasing advertising revenue are making it difficult, if not impossible, to maintain and enhance the present quality of the FMA Journal, without it becoming an increasing fiscal burden upon the FMA budget.

Other actions of the Council on Scientific Activities: (1) The Board of Governors was requested to support the resumption, in subsequent years, of the Deans' Dinner at the annual meeting of the FMA. (2) The Council unanimously commended Dr. George McSwain for his excellent work during the past year as Chairman of the FMA Committee on Medical Schools. (3) Also, the Council unanimously and enthusiastically commended Dr. Clyde Collins for the excellent Centennial Issue of the FMA Journal. (4) In a final action, the Council unanimously recommended to the FMA Committee on Research to meet formally at least once a year. The Council felt that the exchange of much important dialogue, and the education of new members in the scope and function of the Committee, could only be accomplished in such a forum. (5) The Council unanimously requested the Chairman to write a letter of condolence to the Vice-President and Dean of the College of Medicine of the University of Miami, Dr. Emanuel Papper, on the recent death of Mrs. Papper.

Council on Specialty Medicine

The Reference Committee recommended that the Dermatological-Pathology portion of the report of the Council on Specialty Medicine not be adopted.

The Dermatological-Pathology portion of the Council on Specialty Medicine report was not adopted.

The Reference Committee recommended that the portion of the Council report concerning Procedures for Ordering Lab Tests be referred to the Board of Governors.

The portion of the report of the Council on Specialty Medicine concerning Procedures for Ordering Lab Tests was referred to the Board of Governors.

The report of the Council on Specialty Medicine was adopted as amended.

Council on Specialty Medicine

FREDERICK C. ANDREWS, M.D., *Chairman*

The Council on Specialty Medicine has held three meetings during the past Association year, 1973-74; these being on September 9, 1973, in Jacksonville; December 9, 1973, in Orlando; and February 10, 1974, also in Orlando. A special ad hoc committee of the Council, appointed to consider the structure of the Council, held one meeting on December 8, 1973. Attendance at all meetings of the Council has been exceptional and the Chairman is grateful for the interest and cooperation shown by each specialty group representative in the deliberations of the Council.

The following is a summary of the general activities and actions of the Council throughout the year. All of the recommendations resulting from the Council in its deliberations have been submitted to and acted upon by the Board of Governors and are included in the Board's report to the House of Delegates.

Continuing Medical Education—The Council reviewed the role of the specialty groups in the FMA's new mandatory Continuing Medical Education Program. Individual specialty groups have participated in developing the requirements for earning credits in their particular specialty.

FMIT Program—At the request of the Board of Governors, the Council reviewed two claims under the FMIT Program to determine whether the procedures should come under the cosmetic exclusion clause of the Trust. In making its determinations, the Council advised Blue Shield that each case was considered on an individual basis and that a precedent should not be set based on the decisions reached on these two cases.

The Council reviewed the recent changes in the FMIT Program and the discontinuance of coverage for nervous and mental disorders under the Major Medical. The problems created by this change were discussed with the psychiatric representative on the Council. The Council agreed that efforts should be made to solve this problem and possibly establish a basis for continued coverage.

Physician Distribution Report—A report entitled "A Report on Physician Distribution in Florida" prepared for the Community Hospital Education Council by Mr. Robert P. Lawton of the Florida Regional Medical Program and also an abstract of the report prepared by Kenneth E. Penrod, Ph.D. entitled "Physician Supply and Distribution in Florida" was discussed by the Council.

The Council expressed support for more funds for increasing the number of primary care physicians in Florida but not by decreasing existing funds for specialty training. The Council felt that the increase in the number of primary care physicians should occur by increasing the number of graduating M.D.'s entering primary care and not by establishing a new medical school or osteopathic school.

The Council felt that since the total number of physicians graduating from Florida schools or being licensed in Florida from other states is more than adequate, more specific information is needed than is included in the Lawton Report before any recommendations can be made concerning other specialty training and geographic distribution.

The Board of Governors at its meeting in January received as information the Council's recommendation regarding the FRMP Lawton Report. It was the Council's feeling that a position of endorsement of the study needs to be adopted and agreed that the recommendation should be resubmitted to the Board for this reason.

Specialty Group Recognition (Filed for Information —R.C. III)

Pap Smears—It was brought to the Council's attention that Blue Cross-Blue Shield does not reimburse the patient for charges for doing a cervical-vaginal pap smear and has requested additional review of the possibility of making a diagnostic pap smear one additional routine admission procedure on all adult females admitted to hospitals if they have not had one in the preceding one or two years with coverage being provided for this procedure.

Electromyography—The Council reviewed a matter regarding physical therapists doing electromyography without M.D. supervision. The Council has gone on record as being opposed to the performance and interpretation of electromyography by physical therapists or any other non-medical personnel.

Pronouncement of Death—The Council has recommended approval of a resolution from the Florida Neurosurgical Society regarding pronouncement of death. There is currently no law which requires a physician to declare a person dead. The Council felt the whole subject concerning the obligations of private physicians at the time of death needs to be clarified.

Pediatric-Urology—The Council considered a resolution from the Florida Urological Society which would define the training for pediatricians applying for pediatric-urology privileges. The Council did not feel it was their prerogative to define the training of any specialties.

Council's Structure— With the appoval of the Board of Governors, a special ad hoc committee was appointed to review the current structure and composition of the Council, its membership, and also, to review the FMA Criteria for Recognition of Specialty Groups. The committee attempted to make recommendations that would streamline the functions of the Council and still provide representation of all the specialty groups. It was agreed that a steering committee composed of 12 members should be elected by the Council to carry out its business on an interim basis between meetings of the full Council and that this committee would make a report and recommendations to the full Council for their approval or disapproval of the committee's actions. It was agreed that all matters pertaining to the interest of any specific specialty society would be thoroughly reviewed with the representative of that society before being presented to the entire Council. The Council has not proposed any changes in determining the composition of the Council.

Optometry—The Board of Governors had referred a recommendation of the Council on Allied Professions and Vocations to expand its Committee on Opticians in both title and function to include the practice of optometry to the Council for review and recommendation. The Council felt that this would not be necessary because liaison with the optometrists is currently carried out through a committee of the Florida Society of Ophthalmology.

Physicians Assistants—The Council expressed strong opposition to legislation introduced into the Florida Senate regarding the training of physicians assistants. The Council felt that emphasis should be placed on training physicians and not physicians assistants. The bill called for enrollment by 1980 in all programs a total number of physicians assistants equivalent to not less than 50% of the medical graduates of state funded medical schools.

Elective Sterilization Procedures—The Council was advised that the Florida Society of Obstetrics and Gynecology felt that there is a definite need to have insurance companies pay for elective sterilization procedures. The Council concurred that coverage for this procedure for both males and females would be desirable under all insurance programs.

American Optometric Association Stamp Slogan—It was brought to the Council's attention that a letter from the American Association of Ophthalmology has been written to the Postmaster General opposing the proposed postage stamp to commemorate optometry with the statement "Optometry—Your First Line of Defense Against Blindness." The Council expressed support of opposition to the slogan.

State Board of Medical Examiners—The Council was informed by the representative of the Council of Florida District Branches, American Psychiatric Association, of the dissatisfaction with the psychiatric questions on the application blank for examination or licensure by the Board of Medical Examiners. The Council has requested the Board of Governors' assistance in establishing contact with the Board of Medical Examiners to discuss this problem.

UCR Program—The Council reviewed with great interest a slide presentation on the Blue Shield UCR Program. Recommendations were made to the Board of Governors regarding community profiles on UCR Program charges.

Family Practice Legislation—The Council discussed the recent action of the Florida Academy of Family Physicians in development of a bill to help meet the needs of family practice in Florida which had been sent to the members of the Florida Legislature. The Council expressed its support in principle of the concept of legislation for additional monies to be allocated for training family physicians to help meet the needs of family practice in Florida.

Procedures for Ordering Lab Tests—[Referred to Board of Governors] The Council reviewed a request for information as to who has the legal authority to order lab tests, what the basis or restrictions are for ordering these tests, and who is qualified other than physi-

cians, professionals, or osteopathic physicians to request these tests.

The Council concurred in the opinion of the Florida Society of Pathologists that determination of this authority depends entirely on the individual hospital or institution's bylaws where the tests are to be performed.

PEP Program—As a result of concern expressed by government agencies regarding the quality of medical laboratories the College of American Pathologists in 1969 developed a proficiency testing program known as PEP (Proficiency Evaluation Program) as a means of monitoring laboratory performance in physicians' offices. The College has encouraged each state medical association to establish a laboratory quality committee and to recommend PEP to its membership.

The Council felt that members should be encouraged to participate in the Program, but did not see the need for a special committee.

Report of Board of Governors

Council Reports
Council on Specialty Medicine

The Reference Committee recommended that in the Council Reports, portion of the Board of Governors report, the Council on Specialty Medicine section concerning Dermatological-Pathologists, not be adopted.

Council on Scientific Activities

The Reference Committee recommended that the sections of the Report of the Board of Governors concerning Compact for Continuing Medical Education and Continuing Medical Education be adopted as presented.

These reports were adopted.

(See Report of the Board of Governors, page 542)

Resolution 74-2
Pediatric Urology
Broward County Medical Association

The Reference Committee recommended that Resolution 74-2, Pediatric Urology, not be adopted.

Resolution 74-2 was not adopted.

Resolution 74-5
AMA Council on Medical Education
Escambia County Medical Society

The Reference Committee recommended that Resolution 74-5, AMA Council on Medical Education, be amended by adding the word "full-time" between the words "school" and "faculty."

A substitute motion was made from the floor that Resolution 74-5 be adopted as amended and referred to the Board of Governors for presentation at the appropriate time.

The substitute motion carried.

Resolution 74-5
AMA Council on Medical Education
[Adopted as Amended and Referred to Board of Governors for Presentation at the Appropriate Time]

RESOLVED, That Chapter XI, Section 2 (B) of the By-Laws of the American Medical Association be altered to read as follows:

"The Council on Medical Education shall consist of ten Active Members, *of which, not less than one nor more than five shall be a member of a medical school* full-time faculty. Members of the Council shall be elected by the House of Delegates for terms of five years, so arranged that each annual convention the terms of two members shall expire."

Resolution 74-6
Community Medical Education Programs
Area Health Education Centers
Escambia County Medical Society

The Reference Committee recommended that Resolution 74-6 be amended by deleting the words "American Medical Association" in the first RESOLVED and substituting the words, "national medical organizations," and that the Resolution be adopted as amended.

Resolution 74-6 was adopted as amended.

Resolution 74-6
Community Medical Education Programs
Area Health Education Centers

RESOLVED, That the professional physician associations (county, state and national medical organizations) initiate the development of Community Medical Education Programs as Area Health Education Centers under local sponsorship of the medical societies in cooperation with the hospitals and the community, and further be it

RESOLVED, That the Florida Medical Association and the American Medical Association, through appropriate representatives, request State Government and Legislatures to support said Community Medical Education Programs as Area Health Education Centers.

Dr. Fleming: "Your Chairman wishes to thank the members of this Committee, Doctors F. Norman Vickers, Donald G. Nikolaus, William H. Harrison Jr., and Maurice H. Laszlo for their active participation in, and contributions to the deliberations of the group. I wish also to express my appreciation for the fine assistance given the Committee by our secretary, Ms. Marcia Protheroe and Staff member, Mr. Phil Gilbert."

"Mr. Speaker, I move the adoption of the report of Reference Committee No. I as a whole as amended."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. I."

Report of Reference Committee No. II
Public Policy

The Vice Speaker, Dr. Murray, assumed the Chair and called for the report of Reference Committee No. II.

Dr. Andre S. Capi, Chairman, and his committee came forward to present the report of Reference Committee No. II, Public Policy.

Council on Allied Professions and Vocations

The report of the Council on Allied Professions and Vocations, as recommended by the Reference Committee, was adopted as published in the Handbook.

Council on Allied Professions and Vocations

JAMES J. DEVITO, M.D., *Chairman*

The Council on Allied Professions and Vocations held one meeting during the year on September 30, 1973, in Orlando. The following is a summary of the primary activities of the committee under the Council.

Committee on Allied Health Professions—(Dietetics)—There have been no formal meetings of the committee during the year. However, the committee has assisted the Florida Dietetic Association in the development of a dietetic manual for use in small hospitals.

Committee on Dentistry—The committee held no formal meetings during the year. The Chairman maintains direct contact with the President of the Florida Dental Association.

Committee on Law—There have been no formal meetings of the committee, but continued communication with the Florida Bar Association is maintained by the Chairman.

Medical Technologist—There have been no formal meetings of the committee this year. The Chairman reports that there have not been any problems related to him from any medical technology organization.

Committee on Medicine and Religion—The committee held two meetings during the year. On July 15, 1973, and November 4, 1973. Both of these meetings were held in Tampa, Florida.

The committee sponsored the first Annual President's Prayer Breakfast at the Florida Medical Association Annual Meeting in 1973. The Prayer Breakfast was an immediate success and the committee has been asked to sponsor the second Annual President's Prayer Breakfast at the 1974 Annual Meeting.

The committee has approached the medical school of the University of South Florida in Tampa, about co-sponsoring a seminar on Medicine and Religion. The Dean of the medical school was very receptive to the idea and the committee is moving forward in preparation for a seminar to be held later this year.

The committee was successful in adding three advisory clergymen to meet with the committee and assist in any way possible.

Committee on Nursing—The committee held three meetings during the year. These meetings were held on June 10, 1973, in Jacksonville, November 11, 1973, in Orlando, April 7, 1973, in Orlando. Each meeting was held as a joint meeting with the Medical Liaison Committee of the Florida Nurses Association.

The committee was successful in attempting to develop better co-operative efforts in our legislative programs by having a copy of the Association's Legislative Bulletin mailed to the Florida Nurses Association.

The committee also endorsed a resolution adopted by the Florida Nurses Association opposing the concept of institutional licensure which was in turn adopted by the Florida Medical Association Board of Governors.

On the national level, the National Joint Practice Commission has been formed as a co-operative effort between the American Medical Association and the American Nurses Association. This commission has urged each state to set up a state Joint Practice Commission. The Florida Medical Association Committee on Nursing has joined with the Florida Nurses Association Medical Liaison Committee to form the Joint Practice Committee on

Andre S. Capi, M.D., Fort Lauderdale, presides at the hearing conducted by Reference Committee II. Others in picture (left to right) are: Chauncey M. Stone, M.D., Miami; Edward W. Stoner, M.D., Oviedo; Joseph P. Hendrix, M.D., Port St. Joe; Thomas E. McKell, M.D., Tampa; and Recorder Mary Link.

Medicine and Nursing. This joint committee has drafted a joint position statement on practice and established guidelines for the establishment of local joint practice committee on medicine and nursing.

Through the Joint Practice Committee on Medicine and Nursing, the Florida Medical Association has developed a productive exchange of information and enhanced mutual understanding between the two professions.

Committee on Opticians—No formal meetings of the committee were held, but liaison with opticians was maintained through the Chairman. The Chairman has reported that there are fewer and fewer problems arising involving opticians.

Committee on Pharmacy—There have been no formal meetings of the committee during the year. The Chairman has worked with staff in educating legislators and continuing to oppose indiscriminate substitution utilizing generic drugs.

Committee on Physician's Assistants and Medical Assistants—The committee held no formal meetings during the year; however, the Chairman and committee members were involved in a meeting in Gainesville, which was held to discuss the liability problems faced by hospitals.

The committee members have continued to offer individual support to the Physician's Assistants program at Santa Fe Community College and with Dr. Richard A. Henry at the University of Florida.

Establishment of a central placement center has been discussed for sometime and at this time, is operational at the Santa Fe Community College.

The committee feels that this program is of such importance to the profession that the FMA membership should be advised of its existence and provided information relative to obtaining a physician's assistant.

The committee is planning a full meeting with representatives of Santa Fe Community College and the University of Florida next fall. This meeting will have as its main purpose, an updating of the information available from the program and of greater involvement of the medical profession in Florida.

The Council Chairman has received many applications from excellent schools, (Duke, Cleveland Clinic, and others) for Physicians' Assistants placement. However, the Physicians' reception to P.A.'s in this state is not too encouraging.

To our knowledge, there have not been any serious problems with the Physicians' Assistants Program, either legal or medical. This should prove encouraging to those physicians who are at this point, "border line," as to whether or not a physicians' assistant will fit into their practice.

Committee on Physical Therapy and Rehabilitation—The committee held one meeting during the year on September 15, 1973, in Tampa. This was a joint meeting with the Florida Chapter of the American Physical Therapy Association.

The committee is working with the Physical Therapy Association in attempting to clarify the use of electromyography by physical therapists. A recent change in the physical therapy law of the state now allows physical therapists who are qualified to perform electromyography. "Qualified" was to be defined by the Board of Medical Examiners, but the Board has ruled that electromyography may be done by any physical therapist licensed in Florida. The Florida Chapter of the American Physical Therapy Association and the Florida Medical Association Committee on Physical Therapy believe written criteria should be developed outlining the qualifications required for physical therapists to perform diagnostic electromyography and through a combined effort are working towards this.

Committee on Podiatry—The committee held no formal meetings during the year, but continued liaison with the Florida Podiatry Association is maintained by the Chairman.

Committee on Radiologic and Nuclear Medicine Technologists—The committee held no formal meetings during the year. The committee continues to maintain liaison with this group of allied professionals.

Committee on Veterinary Medicine—The committee held one meeting during the year on September 30, 1973, in Orlando. Dr. Charles E. Cornelius, Dean of the College of Veterinary Medicine at the University of Florida, met with the committee to inform them of the progress of the College of Veterinary Medicine. The committee was informed that construction of the college's facilities will begin in the Spring of 1974, with construction to be completed by the fall quarter of 1976. Plans are to have 80 students in the initial class. The college of Veterinary Medicine will operate in conjunction with the medical school as they will use many of the facilities and teaching staff co-operatively. The possible abuses of drugs and syringes purchased for the use of animals was discussed with Dr. Cornelius. Dr. Cornelius stated that veterinarians are very concerned with the area of drug abuse, but as long as large cattle ranches, for example, are able to obtain various drugs for use on their animals, the possibility of drug abuse exists.

One of the major concerns of the Veterinary Medical Association is that they do not have representation on the State Health Advisory Board appointed by the Governor.

Council on Medical Services

The Reference Committee recommended that the words "except in those patients who have been previously sensitized" be added after the word "(HUMAN)" in Recommendation No. 13, and that the report of the Council on Medical Services be adopted as amended.

The Report of the Council on Medical Services was adopted as amended.

Council on Medical Services

RAY E. MURPHY JR., M.D., *Chairman*

During this reporting period, most of the Council's 13 committees were engaged in numerous activities in their varied fields. Many of the committees provide advice on a continuing basis to governmental agencies, legislative committees and various organizations. Thus a share of their recommendations and activities appear in the reports and actions of other bodies.

Several of the Council's standing committees exist only on a standby basis to provide specialized advice when needed which might just as easily be supplied by state specialty groups. There are several other ad hoc and special committees of the Board of Governors which might more properly be placed under the Council due to the nature of their functions. With knowledge of these facts, the Council developed some suggested changes in its structure which were recommended to the Executive Committee and Board of Governors.

In the reporting period, the full Council held one formal meeting, on February 16, 1974, in Orlando, to act upon the annual reports and recommendations of its committees and to consider matters of concern to the Council as a whole. The following consolidated Council report will commence with brief summaries of matters affecting the entire Council and will be followed by short descriptions of each committee's major activities. The Council's recommendations for 1973-74 will conclude the report.

Legislative advice—In preparation for the 1974 regular session of the Florida Legislature, the Council and its committees analyzed a large number of bills of medical and health interest. Recommendations were made for an appropriate Association position on each measure. The expertise of the various committees was made available for legislative consultation and testimony.

Medical care delivery in underserved areas—The broad problem of the delivery of medical services

to underserved population groups has continued to be of concern to the Council. Upon the Council's recommendation, the Board of Governors late in 1973 established a new Committee on Medical Care Delivery to develop innovative approaches to this entire problem in its diversified aspects throughout the state. The Council later requested the Board to change the Committee's name to Committee on Medical Care Delivery Systems to more accurately reflect its function.

University of Florida four-county rural health care delivery project—Following separate review by two of its committees (Rural Health and Public Health and the Environment), the Council carefully reviewed plans for a model coordinated rural health care delivery project to be conducted by the University of Florida College of Medicine in four north Florida counties (Lafayette, Gilchrist, Dixie and Levy) with a combined population of approximately 25,000. The project, to be funded partially by the Robert Wood Johnson Foundation, will involve private physicians, health departments and hospitals in the widespread rural area and will have educational as well as service aspects. The Council suggested that physicians and medical societies in adjacent counties be informed and involved as much as possible in the project.

Nurse-Midwifery—After preliminary study by one of its committees (Maternal Health), the Council became quite concerned with the increasing practice of nurse-midwifery in Florida. A joint study of this matter by various interested groups was recommended.

Resolution 73-23—The Council considered Resolution 73-23, "Community Health Care Projects," introduced by the Pinellas County Medical Society, adopted by the House of Delegates in 1973 and referred to the Council by the Board of Governors. It was the Council's opinion that no further action was indicated on this resolution.

The Committee on Aging during the early part of the reporting period continued to represent the Association on the Florida Joint Council on Health of the Aging, which was dissolved later in the year as a duplication of effort with the recently reorganized Florida Council on Aging, the foremost state group concerned with gerontology and geriatrics. Upon the Committee's recommendation, the Association became an organizational member of the Council. The Committee chairman was named initial chairman of the Council's new Health Section. The Committee is encouraging participation by individual physicians in the affairs of the Council.

The Committee on Child Health remained one of the Association's busiest committees in its role as School Health Medical Advisory Committee to the Department of Education and Division of Health, Department of Health and Rehabilitative Services. During this reporting period, attention has been given to such varied topics as immunization standards, child nutrition, health education degree programs in the state universities, health education in the schools, student and athlete physical examination forms, the confidentiality of school health records, aerobics fitness programs, training courses for teachers in recognizing and working with students with learning disabilities, improvement and funding of school health services and many others.

The Committee on College Health maintained surveillance over the possible expansion of university student health services beyond their campuses and remained abreast of other developments in its field.

The Committee on Emergency Medical Service was active in the various facets of its rapidly-developing area of responsibility. Special attention was given to bringing about an orderly development of medical telecommunications. The Committee recommended and the Council approved the establishment of a new Committee on Medical Telecommunications to devote adequate attention to this subject. The Committee chairman serves as chairman of the state emergency medical service advisory council and as a member of the American Medical Association's counterpart committee.

The Committee on Hearing was available to provide specialized consultation and advice in hearing matters.

The Committee on Maternal Health was active in conducting the Association's continuing statewide maternal mortality survey. The Committee also concerned itself with the practice of nurse-midwifery and the implementation of family planning programs in Florida.

The Committee on Mental Health worked with the Florida District Branches of the American Psychiatric Association in attempting to solve problems in implementing the Florida Mental Health Act of 1972 (the so-called "Baker Act").

The Committee on Mental Retardation was primarily concerned with establishing accurate data about programs and medical services for the mentally retarded and developmentally handicapped in Florida. It maintained liaison with the Division of Retardation, Department of Health and Rehabilitative Services.

The Committee on Occupational Health was available for consultation in matters of industrial and occupational health.

The Committee on Public Health and the Environment was active in dealing with a variety of problems in its broad field. They included the position of children's medical services in the state governmental structure, the treatment and control of tuberculosis, services provided by the Division of Health laboratories, the use of health cards for food handlers, air and water pollution programs, and medical services in jails.

The Committee on Rural Health continued to represent the Association on the joint Florida Committee on Rural Health, in which the state's major organizations and agencies concerned with rural health care problems meet regularly to coordinate and plan their activities. During the period of this report, emphasis has been placed upon improving emergency services and safety conditions in the less densely populated parts of the state.

The Committee on Vision was available to provide specialized consultation and advice in eye care matters.

RECOMMENDATIONS

1. **That the University of Florida's four-county coordinated rural health care delivery project be endorsed and that opportunity be provided for periodic evaluation by the Florida Medical Association.**
2. **That the subject of nurse-midwifery be referred for joint study and recommendations to the Committee on Maternal Health, the Council on Specialty Medicine (Florida Obstetric and Gynecologic Society and Florida Academy of Family Physicians) and the Council on Allied Professions and Vocations (Committee on Nursing).**
3. **That the FMA reiterate its position that the Child Health Section of the Division of Health, Department of Health and Rehabilitative Services, be elevated to bureau status.**
4. **That the Association encourage its members to participate actively as individuals in the Florida Council on Aging through its health section.**
5. **That all physicians be urged to keep the personal element in the doctor-patient relationship by continuing their care to patients who are of necessity confined to nursing homes for extended periods of time.**

6. That the Association encourage the redesign of street curbs for the easier passage of the elderly, handicapped and wheelchairs.
7. That the following resolution be adopted for transmittal through the Council on Legislation and Public Agencies to the Florida Legislature:
   RESOLVED, Since plasmapheresis has been defined by the Florida State Board of Medical Examiners as the practice of medicine, that legislation be enacted to provide for mandatory presence of a knowledgeable, Florida licensed doctor of medicine on the premises of each plasmapheresis center during its hours of operation, and be it further RESOLVED, That adequate funding be provided to enable the Bureau of Laboratories of the Division of Health, Department of Health and Rehabilitative Services, to conduct proper and regular inspections of Florida plasmapheresis centers under the provisions of the Florida Clinical Laboratory Act (Chapter 483, Florida Statutes). (amended—R.C. IV)
8. That any legislation in the area of school health services enacted in 1974 be limited to authorizing and directing the Department of Education and the Department of Health and Rehabilitative Services to jointly develop a state plan for school health services. No appropriations should be necessary for development of such a plan. If the legislators deem it essential to pass a more comprehensive measure on this subject in 1974, it is recommended that the following principles be included:
   (a) That the school health services program shall continue to be a joint responsibility of the Department of Health and Rehabilitative Services and the Department of Education, with a delineation of responsibilities at the state and local levels.
   (b) That implementation shall not begin until a state plan has been developed and officially approved by the two state agencies.
   (c) That there be a provision for the School Health Medical Advisory Committee to continue to act in an advisory capacity to the Department of Education and the Division of Health, Department of Health and Rehabilitative Services.
   (d) That provision be made to arrange for necessary medical and dental treatment for children unable to obtain such services.
9. That the Association seek and encourage the orderly development of emergency medical service telecommunications in close coordination with the Division of Health, Department of Health and Rehabilitative Services and the Division of Communications, Department of General Services, State of Florida.
10. That a standing Committee on Medical Telecommunications be established under the Council on Medical Services to be responsible for all medical telecommunications matters, including coordination of medical telecommunications in the primary area of emergency medical service and including related fields such as continuing medical education and rural medicine. (R.C. III)
11. That emergency medical training for State Troopers of the Florida Highway Patrol be encouraged and supported.
12. That in view of the uncertain legal situation concerning abortions and the impracticality of obtaining meaningful statistics, it is recommended that detailed reporting of terminations of pregnancies not be required.
13. That the FMA recommend that all Rh negative patients undergoing terminations of pregnancies be administered Rho (D) immune globulin (human) except in those patients who have been previously sensitized.
14. That a representative of the Florida Association of County Health Officers be added to a new advisory committee to the Department of Health and Rehabilitative Services on children's medical services.
15. That Senate Bill 769 as revised in January 1974 be endorsed as a "working draft" of desirable legislation authorizing county health departments to provide certain types of health care so long as there is concurrence in these actions by the local county medical society. (Amended—R.C. IV)
16. That Senate Bill 842, relating to home care services as an alternative to institutional care, be endorsed in principle with a suggestion that the licensure and prior institutionalization provisions be clarified. (R.C. IV)
17. That H.R. 12053, the National Health

Policy and Health Development Act of 1974, and all similar bills which would place the practice of medicine in the category of a public utility, be vigorously opposed. (Amended—R.C. IV)

Council on Voluntary Health Agencies

Upon recommendation of the Reference Committee, the report of the Council on Voluntary Health Agencies was adopted as published in the Handbook.

Council on Voluntary Health Agencies

ROBERT E. WINDOM, M.D., *Chairman*

The Florida Medical Association's official "family" of voluntary health agencies continued to grow during the past year. Your Council was pleased to review the application of the Muscular Dystrophy Association of America, Florida Division, for FMA recognition and to report favorably to the Board of Governors upon this application. The 15 voluntary health agencies now recognized by the Association are:

Arthritis Foundation, Florida Chapter
American Cancer Society, Florida Division
Florida Heart Association
Florida Kidney Foundation
Leukemia Society of America, Florida Division
Florida Lung Association
Mental Health Association of Florida, Inc.
The National Foundation—March of Dimes
Florida Association for Retarded Children
National Multiple Sclerosis Society
United Cerebral Palsy of Florida, Inc.
Florida Society for the Prevention of Blindness
Easter Seal Society for Crippled Children and Adults of Florida
Florida Epilepsy Foundation, Inc.
Muscular Dystrophy Association of America, Florida Division

Florida Voluntary Health Association: Almost all of the agencies recognized by FMA are members of the Florida Voluntary Health Association, with which your Council also enjoys a close relationship. Officers of FVHA are invited to Council meetings as are the executive directors of recognized agencies.

The Council was disturbed by word that one of the recognized agencies was considering withdrawal from FVHA and adopted a resolution discouraging this move.

Publications: The Council has revised and reprinted the pamphlet, "Florida Medicine and Voluntary Health Agencies." The Chairman was the author of an article entitled, "Our Greatest Allies—The Voluntary Health Agencies." There were several requests for reprints of this article, and copies were sent to members of Florida's congressional delegation.

Compact for Continuing Medical Education: The Council reviewed a draft of the Florida Compact for Continuing Medical Education as it was approved by the Committee on Continuing Medical Education in August 1973, and discussed it with representatives of recognized voluntary agencies which would be parties to the Compact. Your Council approved the Compact in principle and commended it to individual agencies for consideration.

Rheumatic Fever Task Force: The Council studied and endorsed the Florida Heart Association's proposal to implement a program for rheumatic fever and rheumatic heart disease in Florida through a special task force consisting of representatives of FHA, FMA and the Florida Department of Health and Rehabilitative Services. Your Council was pleased to note that all members of the Task Force were present at the first meeting.

Legislative Alliance: The Board of Governors approved the Council's recommendation that FMA join with the Florida Voluntary Health Association and the Florida Department of Health and Rehabilitative Services in the pursuit of legislative objectives in which the three share a common position.

Legislative Proposals: The Council has recommended to the Board of Governors that FMA support the Florida Division of Vocational Rehabilitation in its request for an additional $10 million in state funds for next fiscal year; and that it oppose in the 1974 Legislature House Bill 2366, relating to charitable solicitations.

Fund Raising: A study of fund raising techniques used by the recognized agencies has been launched by the Council. This investigation will identify and describe the various techniques used and the costs and problems associated with them.

Report of Board of Governors

Recommendation No. 1
Joint Practice Committee

The Reference Committee recommended that Board Recommendation No. 1 be adopted as presented.

It was adopted.

(See Report of Board of Governors, page 532)

Board Action No. 15
Division of Health

The Reference Committee recommended substitution of the word "x-ray" for the word "plates" in the first sentence and adoption of the action as amended.

Board Action No. 15 was adopted as amended.

(See Report of Board of Governors, page 534)

Council and Committees
Allied Professions and Vocations

Upon recommendation of the Reference Committee, the paragraph entitled "Prescriptions for Physical Therapy" was published and filed.

(See Report of Board of Governors, page 535)

Specialty Medicine

The Reference Committee recommended that the paragraph on "Electromyography" in the Specialty Medicine section of the Board Report be published and filed.

It was published and filed.

(See Report of Board of Governors, page 542)

Voluntary Health Agencies

Upon recommendation of the Reference Committee, the paragraphs on "Informal Alliance" and "Rheumatic Fever Program" of the section on Voluntary Health Agencies was published and filed.

Supplemental Report
Committee on Drug Abuse

Upon recommendation of the Reference Committee the Supplemental Report of the Committee on Drug Abuse was published and filed.

Supplemental Report Committee on Drug Abuse

DANIEL SECKINGER, M.D., *Chairman*

During the period of this report, the Committee on Drug Abuse met four times in such widespread locations as Miami, Pensacola, Lake Buena Vista and Tallahassee. The next meeting is scheduled for April 19, 1974. In each of the meetings, drug abuse programs and activities in the surrounding area of the meeting have been reviewed with invited representatives of local groups.

One of the Committee's accomplishments during the past year was the development and adoption of a series of Committee objectives and functions which received the approval of the Board of Governors. Another need which was met was the preparation of an index of the Committee's policies and recommendations since its inception in late 1970.

One of the Committee's strongest assets is its multidisciplinary approach to drug abuse problems resulting from its varied membership of educators, attorneys, law enforcement personnel and others, as well as physicians from different specialties. Information received from other parts of the country indicates that in this respect it is a unique group among drug abuse committees of state medical associations.

The following list of concerns and activities of the Committee represents a very brief summary of its work during the past year.

—The Committee kept abreast of progress of the state drug abuse program and provided advice in a variety of matters to its administering agency, the Department of Health and Rehabilitative Services. An official state advisory council was established to recommend and monitor grants for local and regional programs and projects. Several members of the Committee, including the chairman, were appointed to the advisory council. At the request of the Governor, the chairman serves on a special subcommittee to review the licensing of local and area drug programs. The director of the state drug abuse program serves as a member of the FMA Committee, thus assuring adequate liaison.

—The Committee has been concerned with the general level of medical care available in residential drug treatment facilities and has developed recommendations in this regard. The Committee was the first group to recognize this need in state-sponsored programs and helped bring about a high official priority for medical care in the state drug abuse plan.

—The Committee went on record as favoring a secure state treatment facility for youthful drug abusers requiring such care.

—Increased state funding for laboratory screening for dangerous drugs was recommended and has been incorporated in the state drug abuse plan.

—A study of the effect of public and professional advertising upon drug addiction was undertaken.

—State and national legislation related to drug abuse was followed and advice was provided to legislators.

—Concern was expressed about injudicious prescribing by physicians contributing to drug abuse. Instances of such prescribing were identified and communicated to the FMA membership through Association publications.

—The following policy statement on the Florida Controlled Substances Act was developed and adopted:

"The Florida Medical Association Committee on Drug Abuse is opposed to Section 232(2) Florida Statutes and its counterpart found in the Uniform Drug Act of the State of Florida for the following reasons:

A. The section as written does not take into account any delay in trial which would be detrimental to the student in that the educational process is delayed whereby the student may have to wait a year and a half for trial.
B. The suspension of a student prior to trail is a presumption of guilt, and for non-drug crimes, a student is not suspended.
C. Apparently the law was designed to get "pushers" off the campus but the definition in the law applies to one who may possess very small amounts of drugs and therefore, the definitions are too broad.
D. By expelling the student, it sets him apart and may further promote his association with drug users.
E. If a judge decides to place a student on probation, the student is prohibited from being returned to school because the act provides for automatic expulsion.
F. The amendment to the bill provides for waiver of discipline or expulsion if the pupil commits himself or is court ordered to a state licensed drug program and the problem may be that the student is from an area which does not have a licensed drug program.
G. The State Board of Education has not promulgated any rules relating to suspension of students as provided for in the act.
H. The section provides for waiver if the student divulges information leading to the arrest and conviction of the person supplying the drug and the waiver is not guaranteed and is contingent upon the conviction of the supplier and depends solely upon the principal's determination. The section further allows a waiver if the student voluntarily turns himself in, but again, this section is not an absolute guarantee to the student of the waiver, but is permissive to the one who administers the act.
I. It is the feeling of the Committee that this section prohibits implementation of treatment, education and rehabilitation of the student as well as depriving the student of his normal academic endeavors for indefinite periods of time before adjudication of guilt."

—The Committee studied the need for privileged communication for physicians and schoolteachers in drug abuse matters and recommended that the Association give priority to legislation to accomplish this purpose.

—A questionnaire to county medical societies regarding drug abuse activities was prepared.

—The following policy statement on the use of methadone for the relief of pain in terminal cancer cases was developed:

"With regard to the availability and use of the drug methadone for treatment of pain associated with cancer, the Committee on Drug Abuse, in view of the fact that there are adequate alternate, adjunctive, therapeutically equivalent drugs to accomplish the same results, and recognizing the fact that methadone is becoming a drug of serious abuse, concurs with current federal policies restricting the use of methadone."

—The Committee studied the need for future drug abuse educational programs for which physicians could receive credit under the Association's continuing medical education program.

—The Committee chairman testified by invitation before a special U.S. Senate subcommittee studying anti-drug abuse activities and presented the FMA Committee and the Florida system as a prototype for other states.

—The Committee has served as an intermediary in helping solve regional and local jurisdictional disagreements between official and voluntary drug abuse agencies by providing an arena for joint discussions.

—The chairman by invitation met with the National Advisory Council for Drug Abuse Prevention and described the Committee's activities.

—Through successful litigation involving the sale of tetracycline in Florida, the state received a sizable cash settlement from several pharmaceutical firms. A trust fund was established under the administration of the Attorney General's Office to assure the orderly expendi-

ture of these funds for anti-drug abuse purposes. The chairman and other members of the FMA Committee were appointed to an advisory group for this program.

Resolution 74-29
New Drugs
Dade County Medical Association

The Reference Committee recommended the adoption of a substitute resolution for Resolution 74-29 to be called Substitute Resolution 74-29, New Drugs.

Substitute Resolution 74-29 was adopted.

Substitute Resolution 74-29

New Drugs

RESOLVED, That the Florida Medical Association, recognizing that certain regulations of the U.S. Food and Drug Administration do not take into account (a) the difference in humans and animals and their responses to medicine and diseases; (b) the extreme difficulty in proving efficacy and safety in clinical situations where neither etiology or pathogenesis is completely understood; and (c) the concept of bio-availability as against pure chemical reactions, urge our congressmen to acquaint themselves with these problems so that modifications might be effected; and be it further

RESOLVED, That the FMA finds that these regulations seriously restrict the use of drugs which have been developed and proven effective in other countries and restricts the development of new drugs in this country, and be it further

RESOLVED, That this matter be referred to Florida's delegation to the American Medical Association for study and appropriate action.

Resolution 74-30
"Learning Disability" Program
Dade County Medical Association

Upon recommendation of the Reference Committee, Resolution 74-30, "Learning Disability" Program, was referred to the Board of Governors with the recommendation that it be referred to the appropriate committee.

Resolution 74-30

"Learning Disability" Program

[NOT ADOPTED—REFERRED TO THE BOARD OF GOVERNORS]

Whereas, A syndrome called "Learning Disability" has been recognized for many years, bearing little correlation with intelligence but having a profound effect on certain aspects of learning in our now advanced educational system, and

Whereas, It is also recognized that a Learning Disability is an increasing problem in our schools, affecting close to 20% of our children, and

Whereas, It is also known that 21 states have passed legislation reimbursing the parents of a diagnosed LD child for special education, not provided by the public school system, and

Whereas, A group of parents are currently organizing to seek such aid for reimbursement for education of the LD child; therefore be it

RESOLVED, That the physicians in the State of Florida endorse such a program for the benefit of the LD children.

Dr. Capi: "Your Chairman wishes to thank the members of this committee, Doctors Joseph P. Hendrix, Thomas E. McKell, Edward W. Stoner and Chauncey M. Stone Jr., the members who came to speak before the committee, and our secretary, Mary Arsenault, without whose efforts, cooperation and assistance this report would not have been possible."

"Mr. Speaker, I move the adoption of the Report of Reference Committee No. II as a whole."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee II."

Dr. Walker, FMA Secretary-Treasurer, announced that almost 1,800 physicians were registered for this centennial meeting. This is a total of 500 physicians more than any registration in the history of the Association. In 1966 there were 1,300 physicians registered.

FMA Executive Vice President W. Harold Parham makes an appropriate response upon being awarded the honorary Doctor of Health Administration degree by the University of Florida during a session of the House of Delegates. Participating in the special convocation were (left to right); Bernard J. Fogel, M.D., Assistant Vice President for Medical Affairs, University of Miami; Edmund F. Ackell, M.D., Vice President for Health Affairs, University of Florida; Donn L. Smith, M.D., Dean of the University of South Florida College of Medicine; Jere W. Annis, M.D., Chairman of the University of Florida Medical Advisory Committee; and Chandler A. Stetson, M.D., Dean of the University of Florida College of Medicine.

Report of Reference Committee No. III

Finance and Administration

The Speaker assumed the Chair and called for the report of Reference Committee No. III, Finance and Administration. Dr. Dewitt C. Daughtry, Chairman, and members of his committee came forward to present the report of his committee.

President's Address

The Reference Committee noted the President's Address with great interest and applauded the President for his outstanding leadership during the past year.

The President's Address appears on page 501 of this issue.

Remarks of the Speaker

The Reference Committee noted with pride the effective manner in which the Speaker has conducted the business of the House and recommended that the remarks of the Speaker be adopted.

The remarks were adopted. (The Remarks of the Speaker appear on page 511).

Report of Board of Governors

The Reference Committee reviewed in detail the Report of the Board of Governors and the accompanying audit of the fiscal affairs of the Association as performed by certified public accountants, Lucas, Herndon, Harms and Pennywitt and the Reference Committee found the audit in good order.

The Reference Committee recommended that Recommendation 2 of the Report of the Board of Governors be adopted.

Recommendation 2 was adopted.

The Reference Committee recommended adoption of Recommendation No. 3 of the Report of the Board of Governors as printed in the handbook.

A motion was made from the floor to amend the recommendation by adding, "and that the family be given appropriate notification of what has been done."

The recommendation was adopted as amended.

Upon recommendation of the Reference Committee Recommendation No. 4 was adopted as printed.

The Reference Committee recommended that Recommendation No. 5 be adopted as printed.

The motion was made from the floor to delete the words, "plastic surgeons" and substitute the word "physicians" in Section 5 of the Proposed Statewide Standards for Paid Newspaper An-

Reference Committee III Chairman Dewitt C. Daughtry, M.D., Miami, compares notes with Recorder Sandy Neel as other members of the Committee prepare to go to the next item of business. Left to right from Dr. Daughtry are: Yank D. Coble Jr., M.D., Jacksonville; O. William Davenport, M.D., Miami; Frank C. Coleman, M.D., Tampa; and Robert C. Seelman, M.D., Melbourne.

nouncements by Members of the Florida Medical Association, Inc.

The motion carried.

Recommendation No. 5 was adopted as amended.

The Reference Committee recommended adoption of Recommendation No. 6 as printed in the Handbook.

The motion was made from the floor to delete the words, "plastic surgeons" and substitute the word "physicians" in Section II, paragraph 3, and Section III, paragraph 2 of the Proposed Policy of the Florida Medical Association, Inc. Governing the Listing of Members in Telephone Directories (White and Yellow Pages).

The motion carried.

There was discussion regarding Nuclear Medicine appearing in the listing of approved specialties. Dr. Corso explained that this list was made from the listing they had at the time, but that Nuclear Medicine was now an approved specialty and would be listed in item 4, Section III of the proposed policy for listing numbers in telephone directories.

A motion was made from the floor to amend the approved specialty listing by adding General Practice.

The motion carried to amend paragraph 4, Section III of the Proposed Policy on Telephone Directory Listings.

A motion was made from the floor to amend paragraph 4 of Section III of the Proposed Policy on Telephone Directory Listings by deleting the word "two" in the first sentence and substituting the word "one" and to delete the words "the primary specialty" in the first sentence so as to allow every man the right and privilege to list himself under a single subspecialty for which he is either Board eligible or Board certified according to listings outlined by the American Medical Association.

The motion did not carry.

A motion was made from the floor to amend the listing of approved specialties that appear in paragraph 4, Section III of the Proposed Policy on Telephone Directory Listings by adding Nuclear Medicine.

The motion carried.

Recommendation No. 6 of the Report of the Board of Governors was adopted as amended.

Recommendations No. 7 and 9 of the Report of the Board of Governors were adopted as recommended by the Reference Committee.

The Report of the Board of Governors was adopted as amended, except for those sections referred to other Reference Committees.

Report of Board of Governors

JOSEPH C. VON THRON, M.D., *Chairman*

During the Association year, 1973-74, your Board of Governors has held four meetings. The Board met on May 13, October 11-12, 1973, and on January 13, and March 23, 1974. Your Executive Committee met in conjunction with each Board meeting, and convened for six additional meetings during the year.

Throughout the year, your Officers and Board have given of their time and efforts freely. They have, each and every one, strived to keep the best interest of their colleagues uppermost in their actions.

Again this past year, the activities and actions of your Board during the year that are presented in this report, and the many communications to the membership, indicate the continuing vexing and crucial issues with which organized medicine faces at all levels—national, state and local—many of which threaten the practice of medicine as we cherish it.

Your Board is pleased to report that this report will reflect significant progress and productivity at all levels of Association activity throughout the year. Your Chairman will be ever mindful of the character of the men with whom he has had the privilege of serving this past year. Their dedication is heartwarming and their sincerity gratifying. Moreover, as we celebrate our 100th year as a viable organization, your Chairman is mindful of an honorable profession and its many honorable men—men who have dedicated themselves to human healing, and the integrity and enduring life of our profession. Your Chairman is proud to be a physician and a colleague of such men as those who are the FMA.

Major Activities

During this past year, your Board and Executive Committee has spent over 60 hours in session. The following is a summary of the major activities and actions of the Board in its deliberations.

1974 Annual Meeting—At its meeting in October, the Board approved the format for the 1974 Annual Meeting, and again called on the Committee on Scientific Assemblies to continue its efforts to improve the scientific program and have it completed well in advance.

It was noted that since the FMA would be celebrating its 100th anniversary in 1974, special centennial activities were being planned for the Annual Meeting. Friday, May 10, was designated as "Centennial Day" with a special banquet and program commemorating the 100th anniversary of the FMA.

FMA Leadership Conference—The Florida Medical Association's 16th Annual Leadership Conference for county medical society officers held Saturday, January 26, 1974, in Orlando attracted 176 persons, including 130 physicians. Thirty-four county medical societies participated, representing over ninety percent of the FMA membership.

The all-day conference was followed on Sunday morning by a panel on state and national legislation of interest to medicine.

President-Elect's Conference—The President-Elect held a Conference for County Medical Society Presidents-Elect, September 29-30, 1973, in Orlando. The conference was an instructional forum intended to give county medical society officers an opportunity to express their views. Twenty-seven counties were represented and the conference as a whole was well received.

Financial Statement and Budget—The Board reviewed the financial statement prepared by the Executive Vice President and approved the auditor's statement presented by the Secretary-Treasurer, prepared by Lucas, Herndon,

Harms and Hyers, Certified Public Accountants. This audit report which covered calendar year 1973 showed Association income from all sources was $776,510.52, and total expenses during the year were $711,014.49. This gave the Association an excess $65,496.03 in income over expenses. These figures do not include funds expended for equipment, interest paid as these are carried under fixed assets of the Association, nor does it explain $38,000 in advance dues collected. The net result was the Association just barely was in the black.

The Board approved a budget for 1974 totaling $758,000.00 which is the anticipated income from all sources. In compliance with the By-Laws, the budget was prepared by the Executive Vice President in consultation with the Secretary-Treasurer. It was reviewed by the Executive Committee and approved by the Board of Governors.

Copies of the CPA audit are available to the appropriate reference committee of the House of Delegates and are on file in the Association's headquarters office for review by members of the FMA.

Headquarters—The Board reviewed the overcrowded conditions in the FMA headquarters building, and the adverse effect on the efficiency of the office. The Board has authorized negotiation of a contract for the addition of approximately 4 200 square feet of office space to the headquarters building.

Appointments—The Board of Governors approved the nomination of Burns A. Dobbins Jr., M.D. as the AMA Delegate to serve on the Board of Governors. Jack A. MaCris, M.D. was appointed as optional member of the Executive Committee.

Appointed as advisory members to the Board of Governors were Eugene G. Peek Jr., M.D., Department of Health and Rehabilitative Services; Robert E. Zellner, M.D., Blue Shield of Florida, Inc.; Vernon B. Astler, M.D., Florida State Board of Medical Examiners; and Franklin J. Evans, M.D., Speaker of the House. William J. Dean, M.D. was designated as Public Relations Officer.

Clyde M. Collins, M.D. was reappointed to his fifth one-year term as Editor of *The Journal of the Florida Medical Association*. The Board approved Dr. Collins' nominations of Richard T. Donelan, M.D.; Karl Smiley, M.D.; Gerold L. Schiebler, M.D.; F. Norman Vickers, M.D., and Edward N. Willey, M.D., for Assistant Editors. William M. Straight, M.D. was reappointed as Historical Editor and Richard C. Dever, M.D. designated as the Board of Governors' representative.

The Board also approved the appointment of William M. Straight, M.D. as FMA Historian.

Appointed as chairmen of committees of the Board were:

Subcommittee on Foundations for Medical Care
James L. Borland Jr., M.D., Chm.
Subcommittee on Quackery
Owen F. Agee, M.D., Chm.
Subcommittee on Venomous Snake Bite
Carl E. Andrews, M.D., Chm.
Ad Hoc Committee on Workmen's Compensation
Joseph G. Matthews, M.D., Chm.
Ad Hoc Committee on Indian Health
Richard J. Miller, M.D., Chm.
Fla. Joint Commission on Medical Education
Emanuel M. Papper, M.D., Chm.
Committee on Drug Abuse
Daniel L. Seckinger II, M.D., Chm.
Ad Hoc Committee on Medicaid
Donald G. Nikolaus, M.D., Chm.
Ad Hoc Committee on Government Reorganization
William F. Lindsey, M.D., Chm.
Committee on Liaison with Osteopathy
Jerry F. Cox, M.D., Chm.

Francis T. Holland, M.D. and Burns A. Dobbins Jr., M.D. were elected Chairman and Vice Chairman, respectively, of the FMA Delegates to the American Medical Association.

Awards

The Board reviewed nominations received from county medical societies and selected the recipient of the A. H. Robins Company Award "For Outstanding Community Service by a Physician." This award will be presented at the Centennial Banquet on Friday, May 10, 1974. The recipient for this year's award is included in the delegates' packets.

Layman's Award—The House of Delegates in 1972 established a Distinguished Layman's Award. The purpose of the award is to recognize individuals who have made significant and lasting contributions to the medical profession. The House directed the Board to develop the criteria for establishing the award and further that the Board would select the recipient.

The Board has selected Prevost Coulter of Pensacola as the 1974 recipient of the Distingushed Layman's Award. The appropriate citation, along with criteria, is included in the delegates' packets for information.

Nominations

The Board is pleased to nominate to the House of Delegates two distinguished physicians to receive the Certificate of Merit (the Association's highest honor of achievement) and the Certificate of Appreciation. These nominations are included in the delegates' packets for presentation at the first meeting of the House of Delegates.

Judicial Council—In compliance with FMA By-Laws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1974.

The Board nominates James A. Winslow Jr., M.D. of Tampa to the House of Delegates for re-election to the Judicial Council for Medical District B for a five-year term following his current term which expires in 1974.

Committee on Membership and Discipline—In compliance with the By-Laws, the Board has reviewed terms expiring in 1974 on the Committee on Membership and Discipline. Nominations from county medical societies have been considered and the Board nominates the following physicians for election to the Committee on Membership and Discipline for the terms indicated:

District 1
*William W. Thompson, M.D., Ft. Walton Beach (78)
District 2
*J. Maxey Dell Jr., M.D., Gainesville (78)
District 3
*Samuel L. Alford Jr., M.D., Jacksonville (78)
District 4
*Edwin H. Updike II, M.D., Ocala (78)
District 5
*Randall Jenkins, M.D., Inverness (78)
District 6
+James C. Fleming, M.D., Dunedin (78)
District 7
+Victor H. Knight Jr., M.D., Tampa (78)
District 8
*Woods A. Howard, M.D., Lakeland (78)
+Edwin L. Kamstock, M.D., Sarasota (76)
(Dr. Kamstock is to replace Dr. John M. Butcher, M.D. who resigned.)
District 9
*Theodore I. Kaminski, M.D., Melbourne (78)
District 10
+Robert H. Pare, M.D., Stuart (78)
District 11
*Curtis W. Cannon, M.D., West Palm Beach (78)
District 12
*Henry D. Perry, M.D., Hollywood (78)
District 13
+Sheldon Zane, M.D., North Miami Beach (78)
District 14
*Vincent P. Corso, M.D., Miami (78)
District 15
*Herman K. Moore, M.D., Key West (78)

Blue Shield Board of Directors—The Board selected nominees for election to the Blue Shield Board of Directors from a list of names submitted by the Blue Shield Nominating Committee. Nominees for each physician seat were selected as follows:

Medical District "A"—Three Year Term
James W. Walker, M.D., Jacksonville
John J. Benton, M.D., Panama City
Medical District "C"—Three Year Term
Joseph G. Matthews, M.D., Orlando
Luis M. Perez, M.D., Sanford
Medical District "D"—Three Year Term
Richard C. Clay, M.D., Miami
Henry C. Hardin Jr., M.D., Miami
At Large—Three Year Term
Frank B. Hodnette, M.D., Pensacola
Laudie E. McHenry, M.D., Melbourne
At Large—Remaining Year of Three Year Term
Michael J. Foley, M.D., Melbourne
David A. Giordano, M.D., Sarasota
(To fill the vacancy created by the resignation of Ira Barnett Harrison, M.D. due to illness)

Lay members nominated by the Nominating Committee and approved by the Board are:
Medical District "C"—Three Year Term
William V. Roy, Orlando
At Large—Three Year Term
B. G. Smith, Tampa
Hosp. Admin./Blue Cross Bd. Member—One Year Term
John F. Wymer Jr., West Palm Beach

Florida State Board of Medical Examiners—In compliance with the House of Delegates' policy, the Board of Governors, taking into consideration recommendations by component medical societies, compiled a list of physicians which was forwarded to Governor Reubin Askew for his consideration in making appointments to the Florida State Board of Medical Examiners.

AMA Council on Medical Education—The Board was pleased to submit the nomination of Richard Connar, M.D. for election to the AMA Council on Medical Education.

Referrals by House of Delegates

The 1973 Proceedings of the House of Delegates were reviewed and items requiring study and action were referred to the appropriate councils and committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various council reports as well as in this report.

FMA Membership for Medical Students (1973 Recommendation No. 3, Council on Scientific Activities)—This recommendation pertains to establishing some type of FMA membership for medical students. This recommendation along with the Board of Governors' action regarding FMA membership for medical students and the Judicial Council report regarding medical student membership was referred to the Board of Governors for further consideration by the Judicial Council and the Council on Scientific Activities as there were conflicts in the actions of these bodies. The Board's recommendation to the House of Delegates is included under the By-Laws amendments section of the Board Report.

Comimttee on Nursing (1973 Recommendations No. 4, 5 and 6, Council on Allied Professions and Vocations)—These recommendations pertain to the establishment of a joint practice committee on medicine and nursing outlining the objectives of the committee and also providing for joint position statements on practice. These recommendations were referred to the Board of Governors for an indepth investigation and report back to the House.

RECOMMENDATION NO. 1

The Board of Governors recommends to the House of Delegates that there be established a Joint Practice Committee on Medicine and Nursing and that this committee be called the Joint Practice Committee of Medicine and Nursing and that this committee represent the Florida Medical Association and the Florida Nurses Association, with the members of the Committee on Nursing serving as the FMA representatives on this joint practice committee and that the House of Delegates approve of the Criteria for Joint Position Statements on Practice as Amended:

Criteria for Joint Position Statements on Practice

Over the years, as physicians and nurses have worked together caring for patients, activities in the spectrum of health care have multiplied. This has demanded a reconsideration of the preparation of the physician and nurse as well as a change in their functions. In addition, rapid advances in scientific knowledge and technology, consumer demands, availability of health personnel, and innovations in professional education have magnified the need for adjustments. Realizing this, the Joint Practice Committee on Medicine and Nursing submits the following *Criteria for Joint Position Statements on Practice.*

The Florida Medical Association and the Florida Nurses Association recognize the two distinct, yet complementary, roles and responsibilities of the physician and nurse in the delivery of health services to the citizens of Florida. There have been, and will continue to be, shifts and adjustments in these roles and responsibilities.

In order that our citizens may receive the best possible medical and nursing care, it is essential that physicians and nurses at all levels, state, city, county and individual agency, plan together for delivery of these health services. Mutually developed written protocol will help to clarify responsibilities and should result in improved health care of individuals and families.

The FMA and FNA feel it is of extreme importance to include the following criteria when delegating functions to nurses:

1. That it is safe for, and in the best interest of the patient
2. That the nurse has been adequately taught this function, been judged to be competent, feels competent in performing this function, and written evidence of capability is available.
3. That there is mutually developed written protocol governing the delegated functions and medical consultation is available.

Although this statement is concerned only with physicians and nurses, we recognize the need for all health professionals concerned with health care of people to plan together for the delivery of health services in all health care institutions and to provide for continuing education for all health workers. We also recognize that it is the responsibility of each individual practitioner to maintain and improve his/her proficiency in practice.

It is understood that physicians and nurses are operating under the Medical Practice Practice Act and Nurse Practice Act in the State of Florida.

The Board recommends to the House of Delegates approval of the Guidelines for Establishment of Local Joint Practice Committees on Medicine and Nursing:

Guidelines for the Establishment of Local Joint Practice Committees on Medicine and Nursing

The FMA-FNA Joint Practice Committee favors more frequent communication between nurses and physicians on the local level. This can be accomplished in one or both of the following ways:

1. On a community-wide basis, organized medicine and organized nursing meet together on a regularly scheduled basis to discuss improving methods of delivering medical and nursing services in the particular community.

And/Or

2. In the individual health care setting or agency, representatives of administration, medicine and nursing meet together on a regularly scheduled basis to determine policies governing care of patients in that particular setting or agency.

Steps toward accomplishing the above might include:

a. Review pertinent literature (see bibliography).
b. Organize an informational get-together of representatives of the two groups.
c. Set rules for operation of the committee.
d. Determine objectives for the committee. (See attached examples.)
e. Keep written record of actions taken.

Resolution No. 73-2, "Professional Fees in a Teaching Hospital" (R.C. V. Not Adopted). This resolution was referred to the Board of Governors. The resolved of this resolution states that the Florida Medical Association vigorously protest any new limitation of fees paid for patient care on teaching services given to the physician participating in this care. A copy of this resolution was submitted to the American Medical Association.

This resolution was referred to the Council on Medical Economics for review and recommendations.

Resolution No. 73-18, "Blue Shield Master Medical Coverage" [REFERRED TO BOARD OF GOVERNORS—R. C. V] This resolution was not adopted but referred to the Board of Governors to facilitate the development of a form to eliminate the multiple forms referred to in the resolution. The resolved of the resolution recommends to the Board of Directors of Blue Shield of Florida that Blue Shield basic benefits coverage and Master Medical coverage be paid directly to the physician or to the subscriber, as indicated on doctors service report, without the necessity for multiple forms or multiple assignments in all instances where Master Medical or extended benefits are entitled to be paid.

The Board of Governors referred this resolution to the Council on Medical Economics and the Committee on Advisory to Blue Shield and Fiscal Intermediaries. Blue Shield of Florida has indicated that at the present time it was impossible to piggy-back Major Medical claims.

Board Actions of Major Importance

1. **FMA Reorganization and By-Laws Changes**—Your Board of Governors requested the Executive Committee (which serves as the finance committee and long-range planning committee) to conduct an indepth review with the Executive Vice President regarding council and committee structure and functions to formulate recommendations for revision where necessary. Extensive recommendations were unanimously approved by the Board of Governors on March 23 and will be presented as By-Laws changes in the supplemental report of the Board. These recommendations embody abolishing certain councils and committees and transferring their functions to others. They are a serious endeavor to make the Association more flexible, efficient and result in greater effectiveness.

2. **Florida Prison System-Medical Care Study**—The Board of Governors has expressed willingness to authorize the Florida Medical Foundation entering into an appropriate contract with the Department of Health and Rehabilitative Services to conduct a study of the medical care in the Division of Corrections.

3. **Florida Physicians Association, Inc.**—The House of Delegates in 1972 adopted in principle Resolution No. 71-4 and directed that the FMA organize and sponsor a corporation dedicated to the private practice of medicine. The Florida Physicians Association, Inc. is directly responsible to the FMA.

The FMA has given administrative support to the FPA until such time as it became established. The Board has reviewed the progress of FPA and it was felt that the organization had become self-sufficient and could operate alone. A contract was signed between FMA and FPA for administrative services in the same manner as the Association's agreement with recognized specialty groups.

The Board has approved the listing of the FPA in the "Florida Organizations of Medical Interest, Meetings and Officers" that appears in the FMA Journal.

Under the provisions of the Articles of Incorporation of the Florida Physicians Association, Inc., nominations to the FPA Board of Directors were submitted and approved by the FMA Board of Governors. A summary of the activities of the FPA is included in the Delegates' Handbook.

4. **AMPAC Board**—The Board was pleased to approve the recommendation that Joseph C. Von Thron, M.D., FMA President, be nominated to the AMPAC Board of Directors. Dr. Von Thron was subsequently elected to a one-year term beginning January 1, 1974.

5. **Professional Standards Review Organization (PSRO)**—(Filed—R.C. V)

6. **AMA 1977 Clinical Meeting**—The Board of Governors has extended a formal invitation to the American Medical Association to consider holding its 1977 Clinical Meeting in Florida.

7. **Specialty Group Recognition**—The FMA Criteria for Recognition of Specialty Groups was first adopted by the Board of Governors in 1959. One of the criterion provided that all of the members of the applying specialty group shall be members of the Florida Medical Association. These Criteria were approved by the House of Delegates in 1960 and have since remained in effect. Cognizant of problems of conflict between state specialty groups and their parent national groups regarding membership requirements, the Board amended the mandatory membership requirement. Mandatory FMA membership could be waived by the Board when there are extenuating circumstances. After additional review:

RECOMMENDATION NO. 2

The Board of Governors recommends that criterion No. 6 of the FMA Criteria for Recognition of Specialty Groups which states, "That all of its members shall be members of the Florida Medical Association" be amended to provide that "*100% *of the active eligible* members of the specialty group applying for membership shall be members of the FMA." (*added)

8. **Florida Medical Foundation**—The Board voted that the Officers of the Florida Medical Association, 1973-74, also serve as Officers for the Florida Medical Foundation.

9. **Florida Medical Insurance Trust (FMIT)**—The Board discussed the change in premium and benefits under the FMIT Program. The Board directed that the FMIT Committee be expanded and that the responsibilities of the FMIT Program review be coordinated with the Council on Medical Economics.

The FMIT Committee has also been requested to meet with representatives of the Florida Council of District Branches of the American Psychiatric Association and make available to them actuarial details so that the psychiatric group can work with the FMA and FMIT in identifying possible abuses and possibly establishing a basis for continued coverage for nervous and mental disorders. (R.C. V)

10. **Peer Medical Utilization Review (PMUR) Contract**—Authorization was granted for the Florida Medical Foundation to renew its contract with Blue Shield and the Department of Health, Education and Welfare for Peer Medical Utilization Review activities, based upon the recommendations of the FMA PMUR Committee that $35.00 per hour for physicians performing

actual peer reviews be accepted with the understanding that payment will also be made for preparation time. It was noted that the Florida Medical Association feels that although the contract is acceptable, the payment for physician services is not adequate. (R.C. V)

11. Conference with Chiefs of Medical Staffs—(Filed—R.C. V)

12. Foreign Medical Graduates—The problem of the continuing influx of foreign medical graduates into the State was discussed. There have been requests for physicians to volunteer to practice in foreign countries where there is a definite need for physicians. Many of the foreign medical graduates are coming to the United States to practice when their countries need physicians so badly. It was suggested that possibly there could be some requirement that foreign medical graduates practice in their own country a certain number of years before they could obtain a license in the United States.

The Board reviewed the current trend in licensing physicians in Florida and has asked that the Committee on State Legislation meet with the Board of Governors' representative from the State Board of Medical Examiners and report back concrete proposals on methods of improving the licensure law in Florida.

13. Palm Beach County Medical Society-Foundation for Medical Care—The Board approved the Foundation for Medical Care for Palm Beach County. Additional recognized Foundations include: Duval, Palm Beach, Dade, Escambia, Broward, Orange, Pinellas and Hillsborough.

14. Chiropractic-Medical Examinations of Vehicle Operators—Comments have been filed with the Federal Bureau of Motor Carrier Safety in strong opposition to the petition of the Idaho Association of Chiropractic Physicians which seeks a rule allowing chiropractors to perform medical examinations on operators of commercial vehicles.

FMA component medical societies were advised of the petition and requested to file any comments they deem appropriate with the Bureau of Motor Carrier Safety.

15. Division of Health—The Board endorsed the Division of Health's proposal to discontinue stool cultures, VD tests and chest x-rays for health cards for food handlers; endorsed the proposal that the Division of Health be responsible for setting the charges for health cards in the counties rather than the county commissioners; endorsed the Division of Health's proposal that they employ county health officers as they are needed; and endorsed the proposed policy of the Division of Health to render medical services in the isolated areas of need to special indigent groups with the annual approval of local county medical societies. (amended—R.C. II)

It was announced to the Board that Dr. Wilson T. Sowder, Director of the Division of Health would be retiring in June 1974 after 30+years of service. There was a standing ovation for Dr. Sowder to show the FMA's appreciation for all he has done for public health in Florida.

16. J. Frank Walker, M.D.—The Board was advised that Dr. J. Frank Walker, former Speaker for the AMA House of Delegates, recently passed away.

RECOMMENDATION NO. 3

The Board of Governors recommends to the House of Delegates adoption of a Memorial Resolution regarding J. Frank Walker, M.D., of Atlanta, Georgia, former Speaker of the AMA House of Delegates.

MEMORIAL RESOLUTION

WHEREAS, J. Frank Walker, M.D., of Atlanta, Georgia, was a tireless crusader for organized medicine at all levels; and

WHEREAS, This distinguished radiologist was born in Chicago, Illinois, lived for several years in Jacksonville, Florida, and established himself professionally in Georgia; and

WHEREAS, He was a natural leader, being elected at the age of 39 to the Board of Chancellors of the American College of Radiology and later President of that College, and as Speaker of the House of Delegates of the American Medical Association; and

WHEREAS, The American College of Radiology recognized his many achievements by awarding him, posthumously, its Gold Medal; and

WHEREAS, A chronic illness, which haunted Dr. Walker much of his life, forced his resignation as Speaker of the American Medical Association House of Delegates and caused his untimely death, at the age of 48 on October 6, 1973; therefore be it,

RESOLVED, That the House of Delegates of the Florida Medical Association, in convention assembled, laments the passing of a good neighbor; an outstanding physician; a natural leader of men; and true gentleman; and be it further

RESOLVED, That copies of this resolution be forwarded to Dr. Walker's widow and family; the Medical Association of Georgia and the American College of Radiology.

17. Legal Counsel-Regulatory Boards—The problem of the State Board of Medical Examiners and other state boards in obtaining adequate legal counsel for their business activities was reviewed by the Board. It was felt that the Florida Medical Association could assist, through the Florida Professional Council, the state regulatory boards in obtaining competent legal counsel when needed.

18. Insurance Physicals—The State Board of Medical Examiners had requested FMA's opinion regarding life insurance examinations and measurements. The Board reaffirmed that these examinations are the practice of medicine and should be done in the presence of a licensed physician. A circuit court ruling of February 11, 1974, has rendered a judgement that these examinations do not constitute the practice of medicine.

19. HRS-Fee Schedule—The Board has made recommendations to the Department of Health and Rehabilitative Services regarding establishment of a uniform payment method for physician services to all state agencies in the Department of HRS. If the State of Florida is to properly compensate those physicians for services rendered at the request of the State and payment by it is to attract a broad base of physicians to render this service, a more realistic schedule should be adopted.

The Board expressed the position that the maximum allowance should be at a level which would allow the physician to charge his usual and customary fees for services rendered.

20. Congressional Visitation (1974)—The 1974 Annual Congressional Visitation was held March 18, 1974, following the AMA/AMPAC Workshop, March 15-17 in Washington, D.C. (Amended—R.C. V)

21. Department of HRS-Medical Services Coordinator—One of the most far reaching achievements during the year was the establishment of a Medical Services Coordinator to the Department of Health and Rehabilitative Services. This position will be filled by a physician and will be a direct adjunct to the Secretary of the Department. The position will entail covering all meetings with the Secretary when there are medical implications and responsibility for evaluating all medical services under the Department of HRS.

The Board has also designated the FMA Secretary-Treasurer as the official policy liaison officer with the Medical Services Coordinator for the Association. This was done at the request of the Secretary of the Department of HRS for better communications.

22. Annual Meeting, 1974-Council of Medical Staffs—The Board approved a request of the Council of Medical Staffs for a hospitality suite and sign for the 1974 Annual Meeting, however, their request for exhibit space was disapproved. The Board advised the Council of Medical Staffs that future requests to participate or hold

meetings in conjunction with the FMA can be considered only after their application for recognition by the FMA.

23. **Comprehensive Health Planning; Florida Regional Medical Program**—The Board expressed concern with both the Comprehensive Health Planning Council and the Florida Regional Medical Program. There is an essential need for some very careful evaluation of these programs to make sure that money is not being wasted and to prevent loss of physician input. A joint meeting of all FMA members of the Board of Directors of FRMP with the President and other representatives of the FMA is planned to outline the problems and concerns with regard to the FRMP.

24. **Provider-Based Physicians Workgroup**—The Board considered a report of the Provider-Based Physicians Workgroup; a workgroup composed of intermediaries as well as carriers under the Medicare Program. Their conclusions have the effect that it would be simpler if provider-based physicians were reimbursed through institutions. The Board reaffirmed the policy in support of separate billing and vigorously opposed provider-based physicians being reimbursed through institutions as proposed by the Provider-Based Physicians Workgroup. (R.C. V)

25. **FMA Medical Districts**—Membership in the four FMA medical districts was reviewed and the increases or decreases in membership were noted. The Board did not feel that it was necessary to consider redistricting at this time.

MEMBERSHIP

DISTRICT	JAN. '73	JAN. '74	DIFFERENCE
A–North	1,538	1,643	+105
B–West	2,063	2,262	+199
C–East	2,368	2,598	+230
D–South	2,392	2,578	+186

26. **Community Medical Needs**—The Board of Governors approved sponsorship by FMA of a meeting for communities wishing to present their community medical needs to physician candidates taking the State Board exams, as follows:

(1) The candidate group to be advised that this is purely voluntary and in no way sponsored by the Florida State Board of Medical Examiners.
(2) These would best be given either Sunday afternoon or following the last examination which is normally concluded by Tuesday noon.
(3) The presentations are to be limited to communities and that they not allow individual doctors, groups or hospitals to appear in an effort to solicit associates or partners.

27. **Osteopathic Membership**—The Board received a letter from the Duval County Medical Society requesting the Board institute a By-Laws change allowing doctors of osteopathy to apply for membership in the county medical societies and thereby become members of the State Association. The Board did not elect to institute a change in the By-Laws.

28. **Palm Beach County Medical Society**—The Board of Governors expressed displeasure that the Palm Beach County Medical Society had planned a foreign tour to be held at the same time as the FMA Annual Meeting in May and requested that in the future these activities be scheduled at some time other than the time of the Annual Meeting.

29. **Blue Shield-Chiropractic Claims**—The Board recommended to Blue Shield that chiropractic claims under the Medicare Program be received and processed in the same manner it does any other claims and pay those that are legitimate and deny the others. (R.C. V)

30. **Florida Society of Ophthalmology**—The Board requested Blue Shield reimburse ophthalmologists who assist other ophthalmologists in cataract surgery, with the stipulation that the assistant only be paid after individual consideration of a request from the operating ophthalmologist stating reasons for the need of the assistant. (R.C. V)

31. **Florida Health Planning Council**—The Board expressed opposition to the appointment of chiropractors as provider representatives to the Flordia Health Planning Council and to the several areawide health planning councils in Florida.

32. **Acupuncture**—The Board of Governors reviewed the policy established by the 1973 House of Delegates regarding acupuncture and noted that it was in conflict with the legal definition of acupuncture as established by the State Board of Medical Examiners.

RECOMMENDATION NO. 4

The Board of Governors recommends to the House of Delegates that FMA's present policy statement on acupuncture (Board of Governors' Recommendation No. 11, 1973 House of Delegates) be rescinded; and that the following statement be adopted in lieu thereof:

> **Acupuncture is a medical procedure to be used only by physicians holding unrestricted and unlimited licenses to practice medicine. The Florida Medical Association, in the absence of adequate scientific information at the present time, is unable to vouch for the therapeutic or anesthetic value of acupuncture.**

33. **FMA Insurance Programs**

(PLI)—The FMA sponsored Professional Liability Program entered its second year on January 1, 1974, being underwritten by the Argonaut Insurance Company. There were 4,462 individual policies renewed and 480 P.A. policies as of that date. During 1973, there were 1,089 new applications received. There are 2,730 umbrella policies presently in force.

(Benefit Programs)—A total of eight benefit programs were moved from Marsh and McLennan on November 1, 1973, and are now administered by Harlan-Med, Inc. These include: The Hospital Catastrophe Program, Office Overhead, Excess Major Medical, Accidental Death and Dismemberment, and four Disability Programs.

A new Life Insurance Program was introduced in 1973. This program is needed as a supplemental to the other benefit programs. The newest program, "The In-Hospital Money Plan," will be presented in 1974. This will pay directly to the physician an amount from $20.00 to $100.00 a day for each day in the hospital with double benefits for each day in Intensive Care.

FMA Councils and Committees

The Delegates' Handbook will reflect the many hours of work that have gone into the activities of the Association's councils and their committees. Many physicians have given freely of their time in the programs of the Association, and your Board is grateful for their dedication and interest in improving the quality and quantity of health care for the citizens of Florida. The following is a summary of the Board's actions regarding the recommendations of the councils. A complete summary report on the activities of all the Association's councils appear in the Delegates' Handbook.

Allied Professions and Vocations:

Prescriptions for Physical Therapy Treatment—Because there are no requirements for renewing physicians' prescriptions for physical therapy treatments on workmen's compensation cases, recommendations have been made to the Department of Commerce, Bureau of

Dr. and Mrs. Jere Annis seem to be enjoying the President's Reception.

(Above) Two outgoing Presidents—Mrs. W. H. Mathews (left center), President of the Auxiliary, and Joseph C. Von Thron, M.D. (right center), President of FMA—make one last joint appearance for the benefit of the photographer. They are flanked by their spouses, Dr. Mathews on the left and Mrs. Von Thron at the right.

Old Dr. Abel Baldwin, one of the founders of the Florida Medical Association drops in on the Centennial Meeting of FMA and pays his respects to FMA President-Elect and Mrs. Thad Moseley. Of course, Dr. Baldwin has been dead for many years. Playing the part was Samuel M. Day, M.D., Jacksonville.

(Left to right) Enjoying the Banquet are Richard Stein, Stacy's friend; Stacy Moseley; Mr. William E. Crank, father of Mrs. Moseley; Dr. Moseley; Mrs. Moseley; Dr. Ray E. Murphy Jr.; Mrs. O. J. Keller; Mr. O. J. Keller; Mrs. Ray E. Murphy Jr., and Thad Moseley Jr.

Band leader Sammy Kaye strikes up the band with a little swing 'n sway music after the Centennial Banquet.

Clem C. Benton, M.D., Fort Pierce, is escorted to the head table at the Centennial Banquet to receive the A. H. Robins Company Award for Outstanding Community Service by a Physician. With Dr. Benton are (left) William J. Dean, M.D., a Past President of the FMA; and B. Thomas Whitefield Jr., of the Robins Company.

Former FMA President and Secretary-Treasurer Samuel M. Day, M.D., Jacksonville, receives the Association's highest honor, the Certificate of Merit, from President Joseph C. Von Thron, M.D., as President-Elect Thad Moseley, M.D., Jacksonville, offers a pat on the back.

FMA's second Distinguished Layman Award was presented to Mr. Prevost Coulter (right), a Pensacola newspaper man. Dr. F. Norman Vickers, Pensacola, escorts Mr. Coulter to the podium to receive the award at the Centennial Banquet.

Three of the winners of FMA's four top awards are seated at this table. Counterclockwise from right: Samuel M. Day, M.D., Jacksonville, recipient of the Certificate of Merit; Mrs. Day; Mr. B. Thomas Whitefield Jr., of the A. H. Robins Company; Clem C. Benton, M.D., Fort Pierce, recipient of the A. H. Robins Award for Outstanding Community Service by a Physician; Dr. Benton's daughter; Mrs. Whitefield; William M. C. Wilhoit, M.D., Pensacola, winner of the Certificate of Appreciation; Mrs. Wilhoit; William J. Dean, M.D., St. Petersburg; and Mrs. Dean.

Everybody's happy at this Centennial Banquet table. Left to right: Miss Mary Spanjers, Winter Haven; Mrs. Gordon Ira, Jacksonville; Gordon Ira, M.D., Jacksonville; Mrs. W. H. Mathews, Jacksonville, President of the Woman's Auxiliary; Dr. Mathews; Mrs. Arnold J. Spanjers, Winter Haven; and Dr. and Mrs. Howard DuBose, Lakeland.

Workmen's Compensation, that all cases receiving physical therapy require a written prescription at least every thirty days. (Filed—R.C. III)

Institutional Licensure—The Board approved the concept that institutional licensure be opposed and endorsed the concept of the resolution on the subject which was adopted by the Florida Nurses Association. (Included in the delegates' packets)

Regulatory Boards—The Board concurred that it is absolutely mandatory that regulatory boards preserve their autonomy, current functions, and responsibilities and that professionals regulate and set standards for their own respective boards.

Judicial Council:

Medical Practice Act-Ear Piercing—On March 7, 1974, the Attorney General rendered an opinion that ear piercing does not constitute the practice of medicine.

The Board has expressed strong support for whatever action is necessary to defend the traditional and rightful responsibility of the Florida State Board of Medical Examiners to determine what constitutes the practice of medicine under Chapter 458, Florida Statutes, commonly known as the Medical Practice Act.

Newspaper Announcements—At the request of the Board, the Judicial Council has adopted statewide standards concerning the purchase of newspaper announcements by members of the Association.

RECOMMENDATION NO. 5

The Board of Governors recommends to the House of Delegates approval of informational item No. 1 of the Judicial Council regarding Statewide Standards for Paid Newspaper Announcements by Members of the Florida Medical Association, Inc.

STATEWIDE STANDARDS
FOR
PAID NEWSPAPER ANNOUNCEMENTS
BY MEMBERS OF THE
FLORIDA MEDICAL ASSOCIATION, INC.

1. A member of the Florida Medical Association may purchase newspaper space, subject to the conditions below, for the following purposes:
   - A. To announce the opening of the office of a physician new in the community.
   - B. To announce the relocation of a professional office to a new address or the establishment of a "branch" office. However, newspaper announcements will not be permitted when only a change of telephone numbers is involved.
   - C. To announce the association of a new physician with an established professional office.
   - D. To announce that a professional office will be closed for an extended period (30 days or more) because of illness, vacation, or other cause, and to announce the reopening of the office. However, if the office telephone is to be answered by an employee or answering service, announcements will not be permitted.
   - E. To announce withdrawal or retirement from active practice.

2. It is preferable for a physician to purchase space only in newspapers published in his immediate vicinity. However, it is permissible for him to use any newspaper that can be shown to have a significant circulation within the area from which he normally draws, or could reasonably expect to draw, patients.

3. The number of insertions in any one newspaper should not exceed seven within a 30-day period.

4. Both typography and size of any announcement will be conservative.
   - A. Under no circumstances should size exceed two newspaper columns (maximum of five inches) in width and three inches in depth.
   - B. A physician will not purchase any newspaper space exceeding the dimensions specified in 4A above and attract undue attention to his announcement by surrounding it with excessive white space.
   - C. A mixture of type sizes and faces within the announcement is permissible, but no type size will exceed 18 point.
   - D. Only black ink will be used unless most of the editorial matter on the page is in color, in which case the announcement may be printed in the *one* color that is predominant on the page.
   - E. Use of any pictures, drawings, sketches, logotypes or other illustration is expressly forbidden.

5. The text of each announcement will state the facts in the most simple way possible. Adjectives, adverbs and other descriptive language are to be avoided. Only the degree "M.D." and "D.D.S." or "D.M.D." in the case of some physicians, and "P.A." (for "Professional Association" where appropriate) may be used after a physician's name. No other letters or initials indicating any other degree are permitted.

The following are authorized forms and only slight variations from them are permitted:

JOHN W. DOE, M.D.
Announces Opening of His Office
For the Practice of Family Medicine
110 Main Street
St. Petersburg, Florida
By Appointment 646-7882

JOHN W. DOE, M.D.
Announces Relocation of His Office To
1458 Edwards Street
Tallahassee, Florida
Pediatrics
By Appointment 782-3654

DRS. SMITH AND JOHNSON, M.D., P.A.
Announce the Association Of
Howard W. Green, M.D.
In the Practice of
Internal Medicine and Cardiology
300 West Oak Street
Jacksonville, Florida
By Appointment 388-5662

P. M. SANDPIPER, M.D.
Announces His Office At
58 N. Kanawha Turnpike
Miami, Florida
Will Be Closed Until Further Notice

P. M. SANDPIPER, M.D.

Announces Reopening of His Office

58 N. Kanawha Turnpike

Miami, Florida

By Appointment 356-0551

JOHN M. HAWKINS, M.D., P.A.

Announces His Retirement From

The Practice of Medicine

Effective June 30, 1973

Patients May Contact Office

For Transfer of Records

6. It will be the duty of each component medical society of the Florida Medical Association to make its members aware of these rules and to assure that they are not violated. The county medical society will take disciplinary action as might be indicated against violations, except that the Judicial Council of the Florida Medical Association may intervene as provided in Chapter I, Section 4, of the FMA By-Laws in the event a county medical society fails to take adequate and proper action.

7. Any member who has been charged and found guilty by his county medical society of violating these standards may appeal such finding to the Judicial Council, provided appeal is made in writing within the 30-day period following receipt of notification of the county society's action.

A. Upon receipt of an appeal, the Chairman of the Judicial Council, in consultation with the Chairman of the Committee on Membership and Discipline, will appoint one or more members of the Committee to conduct an independent investigation and to report his or their findings and recommendations to the Council at the earliest possible date.

B. The Judicial Council will render a decision based on the report of the Membership and Discipline Subcommittee and additional information supplied by the accused physician, the county medical society, or other sources.

C. The decision of the FMA Judicial Council will be final, except that it may, at its discretion, grant a motion for reconsideration.

8. These rules will be applied uniformly to all members of the Florida Medical Association, and no county society is authorized to modify them in any way.

9. The Judicial Council will consider any motion of a county medical society for amendments hereto and will render interpretations of these standards upon request.

Telephone Directory Listings—The Judicial Council also investigated the possibility of adopting statewide standards for telephone listings (particularly the yellow pages). The Council submitted guidelines for consideration if statewide standards are adopted.

RECOMMENDATION NO. 6

The Board of Governors recommends to the House of Delegates approval of informational item No. 2 of the Judicial Council regarding statewide standards for telephone directory listings.

POLICY OF THE FLORIDA MEDICAL ASSOCIATION, INC. GOVERNING THE LISTING OF MEMBERS IN TELEPHONE DIRECTORIES (WHITE AND YELLOW PAGES)

I. General Rules

1. Upon recommendation of the Judicial Council, the House of Delegates (Board of Governors) hereby establishes uniform standards for telephone directory listings to be applied in all county medical societies chartered by the Florida Medical Association, and to govern all doctors of medicine who practice anywhere in the State of Florida.

2. Each member of the Florida Medical Association will be individually responsible for having his name listed in a manner consistent with these rules in all telephone directories published on or after July 1, 1975.

3. All county medical societies which have in any way restricted, or prescribed rules or standards for, telephone directory listings within their jurisdictions shall take steps to rescind, annul, or abrogate any such rule, statement of policy, ethic or by-law not later than June 30, 1975.

4. On and after July 1, 1975, no component society chartered by the Florida Medical Association shall make any effort to promote any deviation from these standards among their members, nor shall they discipline any member because he adheres to these standards.

5. Each county medical society ethics committee, or some other committee which performs similar functions, will be responsible for enforcing these standards within the jurisdiction of that society. In addition, the committee will take appropriate disciplinary action against any member found to have violated these standards. Each violation and a report on the disposition of each case, including the disciplinary action taken against the violator, will be reported to the Judicial Council within 15 days.

6. Any member found guilty by a county medical society ethics committee of violating these standards may appeal either the finding or the form of disciplinary action, or both, to the FMA Judicial Council.

7. In appeals, the judgment of the Judicial Council of the FMA will be final, and there will be no right of appeal to higher authority.

8. Only the Judicial Council of FMA shall have authority to grant exceptions to these rules.

II. Rules Governing "White" Page Listings

1. A physician may list his name, address, and telephone number in the white pages of any telephone directories that are published primarily for a city, town or other area in which he maintains a residence or an office, or both. He may list both residence and office.

2. Generally, a physician may have his name, address and telephone number listed in the white pages in much the same manner as other professional people, except that he must not permit any part of his listing to be printed in bold face type.

3. The physician's degree (M.D.) and the notation P.A. (if applicable) may appear after his given name, but no other designations, degrees or descriptions are permissible. (Exception: physicians may also use D.M.D or D.D.S. if they have earned dental degrees.)

4. A physician may not list in the white pages any professional information other than his office address and telephone number. He may, however, list an alternate telephone number in case of no answer.

5. A physician need not list his residence if he prefers not to.

6. The following examples are acceptable professional listings in the white pages:

A 1.	Business Listings	
	Dabbs Geo 818 Curtice	836-3131
	Dabney Jas H MD 326 22	241-6138
	Dagner Ray W.	
	567 Dover Pl.	693-6615
	Dampier Earl 144 N River	878-3350
	Daniel Jos A MD	
	2934 Carskadn	472-2131
A 2.	Alternate Calling Arrangement	
	If No Ans Call	246-3601
	Daniel Phyllis	
	2705 IshaLaye Dr.	531-2713
	Darling Floyd A MD	
	3939 Monroe	479-4433
	Res 1020 Glann	536-5074

If No Ans Call 246-3601
Dasher C E MD
1838 Parkwd 241-9512

A 3. Business Listing followed by Residence Listing
Res 2347 Robnwd 244-8413
Datz Geo W 928 Prospct 248-3650
Dement Wm R 2332 Bodet 472-3583
Denmark Wm T MD

A 4. Multiple Office Listings
1614 S Byrne 882-6618
2140 Scotwd 242-9595
Res 3531 Secor 536-0790
Denner C L 2237 Evrgn 536-4257
Denner Clarence
2111 Brancaster 536-2809
Deutsch Robt K Consltnt
Security Bg 244-7285
Deutsch Wm R
3545 Camille Dr. 382-3944
De Vanna Harold A MD
Secor Hotel 241-4830
Res 3033 Wstchstr 536-7444

A 5. Complete White Pages Listing Arrangement
Family's Teleph
3033 Wstchstr 536-2337
If No Ans Call 246-3601
DIAMOND SHIPPERS BOX CO
350 Morris 243-9246
Dober Corp 128 Summit 242-2319
DOCTORS AUDTNG SERV
Gardner Bg 255-8400
Doctors Bldg Parkwd
& Monroe 246-9814

III. Rules Governing "Yellow" Page Listings

1. A physician may list his name, address, and telephone number in the yellow pages of any telephone directories that are published primarily for a city, town or other area in which he maintains a residence or an office, or both. He may list both residence and office.

2. In yellow page listings of doctors of medicine, it is preferable for the physician's name to be followed by the abbreviation "M.D." and "P.A." (if applicable). No other initials indicating degrees, etc. may be used except that physicians may use "D.D.S." or "D.M.D." if they have earned dental degrees.

3. Physicians' names should be listed alphabetically under the heading of "Physicians and Surgeons, M.D." or whatever similar heading is used by the local telephone company in the classified section of the telephone directory. It is permissible in this general alphabetical listing to follow the physician's name with the simple statement "Practice limited to ——————,"

4. In addition to the regular alphabetical listing, a physician may list himself under no more than two specialty or subspecialty headings, provided he is Board certified or qualified in, or limits his practice to, the primary specialty, and provided further that the specialty or subspecialty is recognized by the American Medical Association and the Advisory Board for Medical Specialties. The following are considered proper specialty listings, and any additions must be approved by the Judicial Council:

Physicians & Surgeons, M.D.
Aerospace Medicine
Allergy
Anesthesiology
Broncho-Esophagology
Cardiovascular Diseases
Dermatology
Diabetes
Endocrinology
Emergency Medicine
Family Practice
Gastroenterology
General Practice
General Preventive Medicine
Geriatrics
Gynecology
Hematology
Hypnosis
Infectious Diseases
Internal Medicine
Laryngology
Legal Medicine
Neoplastic Diseases
Nephrology
Neurology
Neurology, Child
Neuropathology
Nuclear Medicine
Nutrition
Obstetrics
Obstetrics and Gynecology
Occupational Medicine
Ophthalmology
Otology
Oto-rhinolaryngology
Pathology
Pathology, Clinical
Pathology, Forensic
Pediatrics
Pediatrics, Allergy
Pediatrics, Cardiology
Pharmacology, Clinical
Physical Medicine and Rehabilitation
Psychiatry
Psychiatry, Child
Psychoanalysis
Psychosomatic Medicine
Public Health
Pulmonary Diseases
Radiology
Radiology, Diagnostic
Radiology, Pediatric
Radiology, Therapeutic
Rheumatology
Rhinology
Surgery, Abdominal
Surgery, Cardiovascular
Surgery, Colon and Rectal
Surgery, General
Surgery, Hand
Surgery, Head and Neck
Surgery, Neurological
Surgery, Orthopedic
Surgery, Pediatric
Surgery, Plastic
Surgery, Thoracic
Surgery, Traumatic
Surgery, Urological

Each physician who uses multiple listings must be prepared to justify these listings if called upon to do so.

4. In large metropolitan areas, it is permissible to divide the yellow page listings into geographical areas such as "Downtown," "Beaches Area," "North County," "South County," etc. However, a physician is permitted to list himself only under those geographical areas in which he maintains an office for the examination and treatment of patients.

5. In addition to name, address and telephone number, a physician may place the following additional information under his name:

A. A statement that the physician's practice is limited may appear under the general listing only. (Example: Practice limited to pediatrics)
B. A brief statement of office hours or a note that patients are seen by appointment only.
C. An alternate telephone number or answering service number.

6. The following will not be permitted in either general or specialty listings:

A. Bold face type
B. Listings boxed by lines or rules
C. Any statement such as "Diplomate of the American Board of ——————," or "Fellow of the American College of ——————," etc.
D. Any language, symbol, or device that tends to direct attention to one particular listing or that could be construed as advertising.

7. It is permissible—and even encouraged—for county medical societies to purchase a display or box advertisement to list their address, office hours and services for the public; e.g., emergency medical service and assistance in selecting a physician.

IV. Enforcement

1. Each member of the Florida Medical Association will be held accountable for his listing. It is the duty of each county medical society to make its members aware of these rules.

2. All suspected violations will be reported by the county medical society or individual society member to the Judicial Council.

3. A physician found to be knowingly and willfully violating these rules will be subject to appropriate disciplinary action consistent with the by-laws of his county medical society and the Florida Medical Association.

4. The Judicial Council recognizes that these rules may not cover every situation. Therefore, it might be inclined to grant exceptions from time to time based on the merits of individual cases.

State Funds—The Board expressed support for procurement of state funds to compensate members of the Membership and Discipline Committee for time spent as deputy investigators for the Florida State Board of Medical Examiners.

State Board of Medical Examiners-Per Diem—The Board supported proposals to increase the per diem compensation for members of the Florida State Board of Medical Examiners.

Membership Transfers

RECOMMENDATION NO. 7

The Board of Governors recommends to the House of Delegates that Levy County be transferred from the Jurisdiction of Marion County Medical Society to Alachua County Medical Society in view of the fact that the three physicians residing there are members of the Alachua County Medical Society.

Legislation and Public Agencies:

Death with Dignity

RECOMMENDATION NO. 8

[REFERRED BACK TO THE BOARD OF GOVERNORS FOR OBSERVATION AND CONSIDERATION.—R.C. IV]

The Board of Governors recommends to the House of Delegates that the Florida Medical Association adopt the following position in regard to Death with Dignity Legislation:

It is established present law that a person has a perfect right at any time in his life in any stage in a particular illness to refuse all medications or treatment of any kind. The right to die with dignity or the cessation of the employment of extraordinary means to prolong the life of the body when biological death is certain and inevitable, is the decision of the patient and/or his immediate family with the approval of the family physician, or the physician in charge, as the case may be. Legislation to accomplish this purpose is not only unnecessary, but could lead to legal complications placing the physician under the impossible burden of satisfying simultaneously his professonal training and judgment and legalistic and public consensus requirements. In the final analysis, such medical matters as the criteria of death, or the time of death, or what constitutes death with dignity are the physician's responsibility requiring professional judgment, and should not and ought not be the subject of legislation.

For these reasons, the Board of Governors of the Florida Medical Association opposes death with dignity type of legislation. (R.C. IV)

Milk Inspection—The Board approved support for sustaining the Governor's veto on House Bill 1166 which would transfer responsibility of milk inspection from the Department of Health to the Department of Agriculture. (R.C. IV)

"Active Opposition"—(Filed—R.C. IV)

Department of HRS-Reorganization—The Board has approved a position that regardless of the final FMA legislative objectives in the area of governmental reorganization, a fundamental principle of the FMA be that physicians must be charged with the administration of the State's health programs.

The Board requested the Committee on Government Reorganization to continue close attention to the intentions to make major changes in reorganization in the Department of Health and Rehabilitative Service to make sure that the appropriate FMA input is achieved.

Peer Review-Medicaid—The Board approved establishment of a peer review mechanism for Florida's Medicaid Program at the earliest possible date.

Medical Economics:

Usual, Customary and Reasonable (UCR)—The Board of Governors has reviewed the usual, customary and reasonable concept. The Council on Medical Economics has expressed concern with the UCR Program which was outlined by the Council in its annual report and included in the Delegates' Handbook.

Outpatient Surgical Centers—The Board approved a recommendation to the Blue Shield Board that the Blue Cross Board be asked for their consideration of a suggestion that any additional charge for a technical component generated by a free standing surgical center or any other outpatient surgical facility be paid by Blue Cross rather than Blue Shield and that adequate peer review be done, with care being taken to insure that reimbursement should only be for those procedures which are routinely performed in an inpatient hospital setting and not in a doctor's office. (R.C. V)

Committee of 17 Meetings-Guests—The Board agreed that prior to Committee of 17 meetings, committee staff should contact county medical societies near the location where the meeting is to be held, and invite officers of these societies to attend as non-voting guests. (R.C. V)

Resolution 17-47-72—The Board has suggested to the Blue Shield Board that an article on the Medicare B WATS Validation Program be published again in the Medicare Newsnotes so that all physicians can understand the Program and further that an article be written for dissemination through proper FMA publications.

Blue Shield Annual Meetings—A request was transmitted to the Blue Shield Board of Directors to consider instituting an educational program during their Annual Meeting in place of bringing in outside speakers.

Hospital Utilization Committees—The Board expressed approval of the concept that hospital utilization committees be paid for time spent in review when required by governmental agencies. (R.C. V)

Hospital Medical Staffs—The Board reaffirmed policy that members of hospital medical staffs have representation on the governing bodies of the hospital; and that this policy be communicated to the Florida Hospital Association and each individual hospital licensed in the State of Florida.

Insurance Claims—The Board received a request to investigate physicians who are charging $2.00 for completing every insurance attending physician's statement. The Board acknowledged the AMA Judicial Council opinion that, "the attending physicians should complete without charge the appropriate 'simplified' health insurance council forms approved by the Council on Medical Service, and similar insurance claim forms as a part of the physician's service to the patient to enable him to receive his benefits." "A charge for more complex forms may be made in conformity with local custom. This suggestion is advisory. In all cases, the local medical

society can be looked to for an authoritative opinion." (R.C. V)

Fees for Assisting in Surgery—The Board expressed the feeling that when a surgeon acts as a co-surgeon in a particular operation where he is paid for his specific part of the procedure, he should not be allowed to charge an additional assistant's fee. (R.C. V)

Aetna Insurance Company—The Board expressed strong regret and displeasure over the improper practices of Aetna Life and Casualty Company and firmly believes that:

(1) Aetna should, in no way, attempt to set physicians' fees.
(2) Aetna has no right to contact a patient and tell him he has been overcharged.
(3) Aetna should not make statements regarding the ethics of a physician.
(4) Aetna should refer insureds to local county medical societies with any grievances concerning fees.

This action has been transmitted to Aetna Life and Casualty Company, the Health Insurance Council, and the State Insurance Commission, as well as to the American Medical Association. (R.C. V)

Assignment of Blue Shield Claims—The Board expressed dismay to the Blue Shield Board of Directors that FMA was not consulted or notified of the change in Blue Shield policy of paying non-participating M.D.'s directly when a basic claim was submitted with a duly signed assignment as communicated in the December 1970 Blue Shield Newsnotes and that the change made in 1972 by the Blue Shield Board was never communicated to Florida physicians. The Board requested the Blue Shield Board to reconsider its decision, and pay non-participating M.D.'s directly when basic claims are submitted with a signed assignment of benefits from the patient. (R.C. V)

Confidentiality of Medical Records—The Board approved, in cooperation with the Florida Hospital Association, the institution of a review of the procedure for obtaining confidential hospital records.

Blue Shield Refund Requests—The Board recommended to the Blue Shield Board that when an error in payment is made to a physician under Blue Shield private business and this error is not a result of physician error in claim filing, that a time limit for requested refunds of 90 days from the date of processing be implemented. (R.C. V)

Physician Workshop—The Board approved FMA co-sponsorship of an AMA/ERF Practice Management Workshop in November 1974 for new physicians entering private practice.

Health Maintenance Organizations (HMO's)—The Board authorized continued investigation of the contract concept with the Department of HRS for the proposed "Foundations Prepaid Health Plan for Medicaid in Florida" without any commitment to the Foundation.

Resolution No. 73-12, "In-Hospital Test Charges"—The Board reaffirmed Resolution No. 73-12, "In-Hospital Test Charges" be carried out through direct contact with the Florida Hospital Association. This resolution resolved that the Florida Medical Association urge county medical societies to request that each hospital staff be provided by their hospital administration, with a current list of charges for all services, to be placed at multiple, accessible locations. (R.C. V)

Health Insurance Association—The Board agreed that negotiations with the Health Insurance Association of America should proceed with implementation at the earliest possible date of an arrangement with HIAA for peer medical and utilization review for the private sector of health insurance. (R.C. V)

Blue Shield Doctors Service Report—The Board requested the Blue Shield Board of Directors to consider pre-printing a box on the present Blue Shield Doctors Service Report which could be checked by a physician for physician review by the Blue Shield Medical Division prior to processing of the claim, and further recommended to Blue Shield that sufficient physicians be hired at adequate compensation to provide current and competent claims review in implementing this recommendation. (R.C. V)

Blue Cross Half-Days Hospital Charges—The Board recommended to Blue Shield that it be suggested to the Blue Cross Board of Directors that the practice of not paying hospital charges for half-days be discontinued, and that Blue Cross pay for half-days when charged by hospitals. (R.C. V)

Health Insurance Review—The Board modified the operating procedures of the Committee on Health Insurance to provide a 60-day time limit for appeals to the State Committee from the time a county medical society's decision is rendered. The Board also requested that county medical societies inform the physician involved of the date, time and place of the review of insurance claims. The insurance company may be advised if desirable. (R.C. V)

Scientific Activities:

Compact for Continuing Medical Education—The Board approved the adoption of the Florida Compact for Continuing Medical Education of Physicians.

The Board also approved a proposed mechanism for certifying hours of continuing medical education.

Continuing Medical Education—The Board requested the Committee on Continuing Medical Education to develop a statewide plan relating to the accreditation of continuing medical education programs which do not have automatic direct review by the AMA. Such program to be evaluated only upon the request of the sponsoring group or institution and to be primarily programs developed and offered in local areas. (R.C. I)

Medical Schools—The Board submitted to the State Board of Medical Examiners a recommendation that Section 458.13, Sub-Section (k) Florida Statutes (Medical Practice Act) be amended to provide that a faculty teaching certificate may be renewed for an additional two-year period upon the request of the dean of the respective medical school and at the discretion of the Board, such a certificate could be renewed annually up to a maximum of three years provided that the certificate holder take the Florida Medical Board examination in each of those three years.

Florida Regional Medical Program—The Board recommended once again that FRMP, Inc. separate the office of state chairman and president as previously requested by the House of Delegates in 1972.

Specialty Medicine:

Electromyography—The Board opposed the unsupervised performance or interpretation of electromyography by physical therapists or any other medical personnel other than a physician. (Filed—R.C. II)

Pronouncement of Death—The Board adopted a resolution of the Florida Neurosurgical Society regarding pronouncement of death in hospitalized patients. (Included in delegates' packets)

Ophthalmology—The Board expressed opposition to the slogan, "Optometry—Your First Line of Defense Against Blindness" to be used to commemorate optometry on a U.S. postage stamp.

Florida Regional Medical Program Lawton Report—The Board adopted a position of endorsement of the Florida Regional Medical Program Lawton Report on "Physician Distribution in Florida" and transmitted this endorsement to the Florida State Board of Regents.

Hospital Staff By-Laws—The Board approved a recommendation that all hospital staff by-laws be sufficiently amended to include the fact that requests for lab tests and x-rays be submitted by a licensed medical doctor or osteopath.

PEP Program—The Board encouraged all FMA members to participate in the PEP (Proficiency Evaluation Program) Program sponsored by the College of American Pathologists, and directed that information regarding the Program be included in the FMA Jounal or in a brief to the membership.

Voluntary Health Agencies:

Informal Alliance—The Board agreed that FMA enter into an informal alliance with the Florida Voluntary

Health Association and the Florida Department of Health and Rehabilitative Services to pursue certain legislative objectives in which the three agencies share a common position, with the understanding that FMA's participation will be coordinated with the Council on Legislation and Public Agencies and other appropriate FMA authorities. (Filed—R.C. II)

Rheumatic Fever Program—The Board expressed FMA support of the proposal of the Florida Heart Association to implement a program for rheumatic fever and rheumatic heart disease in Florida through a special task force consisting of representatives from the Florida Heart Association, the Florida Medical Association, and through the Division of Health. (Filed—R.C. II)

Voluntary Health Agencies Recognition—The Board approved official FMA recognition renewal for 1974-75 for the following voluntary health agencies which have met the criteria established by the Association:

Arthritis Foundation, Florida Chapter
American Cancer Society, Florida Division
Florida Heart Association
Florida Kidney Foundation
Leukemia Society of America, Florida Division
Florida Lung Association
Mental Health Association of Florida, Inc.
The National Foundation—March of Dimes
Florida Association for Retarded Children
National Multiple Sclerosis Society

The Board approved tentative recognition for 1974-75 for the following voluntary health agencies pending review of additional material to be presented by them:

United Cerebral Palsy of Florida, Inc.
Florida Society for the Prevention of Blindness
Easter Seal Society for Crippled Children and Adults of Florida
Florida Epilepsy Foundation, Inc.
Muscular Dystrophy Associations of America, Florida Division

RECOMMENDATION NO. 9

After careful consideration, the Board of Governors submits the following recommendations to the House of Delegates for amendments to the FMA By-Laws.

FMA Membership for Medical Students

The Board of Governors recommends to the House of Delegates that the By-Laws of the Florida Medical Association be amended to create a category of student membership for students enrolled in approved medical schools in Florida, and if medical student members are charged dues, the dues exemption for interns and residents are to be re-evaluated.

CHAPTER I—MEMBERSHIP, Section 1, Qualifications and Eligibility.

Amend by inserting "1." before the existing language and by adding:

"2. BONA FIDE STUDENTS ENROLLED IN ACCREDITED FLORIDA MEDICAL SCHOOL CURRICULA LEADING TO THE DEGREE OF DOCTOR OF MEDICINE SHALL BE PRIVILEGED TO APPLY FOR MEMBERSHIP IN THE FLORIDA MEDICAL ASSOCIATION, INC., THROUGH AN EXISTING COMPONENT MEDICAL SOCIETY."

CHAPTER I—MEMBERSHIP, Section 2, Classifications.

Amend first sentence to read:

"The Association shall be composed of Active Members, Associate Members, AND STUDENT MEMBERS."

CHAPTER I—MEMBERSHIP, Section 2, Classifications.

Amend by adding after Subsection 8:

"STUDENT MEMBERS MUST BE ENROLLED IN A COURSE OF STUDY LEADING TO THE DEGREE OF DOCTOR OF MEDICINE."

CHAPTER I—MEMBERSHIP, Section 3, Rights and Privileges.

Amend second sentence of the first paragraph to read: "Each doctor of medicine AND STUDENT, by accepting membership in the Association, becomes subject to all provisions of these By-Laws, and subject to disciplinary proceedings authorized hereunder."

CHAPTER I—MEMBERSHIP, Section 3, Rights and Privileges.

Amend by adding the following paragraph after all existing language:

"STUDENT MEMBERS SHALL ENJOY THE RIGHTS AND PRIVILEGES ACCORDED ACTIVE MEMBERS EXCEPT THAT THEY SHALL NOT HOLD OFFICE OR CHAIR COUNCILS OR STANDING COMMITTEES THAT ARE SPECIFICALLY MENTIONED IN CHAPTER VIII AND CHAPTER IX OF THESE BY-LAWS. THEY WILL BE REPRESENTED IN THE FLORIDA MEDICAL ASSOCIATION HOUSE OF DELEGATES BY ONE OR MORE VOTING DELEGATES. THEY WILL BE ELIGIBLE FOR APPOINTMENT TO THE COMMITTEES AND COUNCILS OF THE ASSOCIATION. EACH STUDENT MEMBER SHALL RECEIVE AN ANNUAL SUBSCRIPTION TO THE JOURNAL AND ONE COPY OF THE CURRENT FLORIDA MEDICAL DIRECTORY."

CHAPTER IV—HOUSE OF DELEGATES, Section 6, Determination of Delegates.

Amend by inserting the following paragraph after the first paragraph:

"THE STUDENT MEMBERS OF A COMPONENT MEDICAL SOCIETY WITHIN WHOSE JURISDICTION A SCHOOL OR COLLEGE OF MEDICINE IS LOCATED SHALL BE ENTITLED TO SELECT ANNUALLY ONE DELEGATE. THIS DELEGATE MUST BE APPROVED BY THE COUNTY MEDICAL SOCIETY AND WILL BE IN ADDITION TO THOSE CHOSEN TO REPRESENT REGULAR MEMBERS AS PROVIDED ELSEWHERE IN THESE BY-LAWS."

Burns A. Dobbins, M.D., Ft. Lauderdale, addresses the House of Delegates on the matter of PSROs.

CHAPTER IV—HOUSE OF DELEGATES, Section 6, Determination of Delegates.

Amend the existing second paragraph to read:

"The House of Delegates shall be limited as nearly as possible to a maximum of 250 regularly elected members from county medical societies, AND ONE STUDENT DELEGATE FROM EACH COMPONENT SOCIETY, IN WHOSE JURISDICTION A COLLEGE OR SCHOOL OF MEDICINE EXISTS. The Board of Governors, etc."

CHAPTER VII—BOARD OF GOVERNORS, Section 1, Composition.

Amend third paragraph to read:

"The Board at its discretion may select to serve on the Board of Governors in an advisory capacity, for a term of one year each, a representative from the Florida Department of Health and Rehabilitative Services, from the State Board of Medical Examiners, and from the Board of Directors of Blue Shield of Florida, Inc., AND A MEDICAL STUDENT REPRESENTATIVE, all of whom must be members of the Association."

CHAPTER IX—COMMITTEES, Section 2, Composition, Selection and Tenure of Committees.

Amend by adding a Subsection 12 as follows:

"13. COMMITTEE ON MEDICAL STUDENTS.—THIS COMMITTEE SHALL INCLUDE FIVE MEMBERS APPOINTED BY THE PRESIDENT TO REPRESENT THE FOUR MEDICAL DISTRICTS AND THE MEMBERSHIP AT LARGE IN A MANNER PRESCRIBED ELSEWHERE IN THIS SECTION. IN ADDITION, THE PRESIDENT SHALL APPOINT TO THIS COMMITTEE FOR TERMS OF ONE YEAR EACH ONE STUDENT MEMBER REPRESENTING EACH MEDICAL SCHOOL OR COLLEGE."

CHAPTER X—INCOME AND EXPENDITURES, Section 2, Dues, Subsection 1, Annual Dues.

Amend Subsection 1, as follows:

"1. Annual Dues.—Annual dues shall be assessed, as hereinafter provided, by the House of Delegates and shall currently be $75.00 per year for active members, $25.00 per year for associate members, AND $10.00 PER YEAR FOR STUDENT MEMBERS, except that medical interns etc."

CHAPTER X—INCOME AND EXPENDITURES, Section 2, Dues, Subsection 2, Entrance Fee.

Amend Subsection 2 as follows:

"2. ENTRANCE FEE.—Each new active or associate member, except STUDENT MEMBERS, interns, residents and fellows in approved training programs approved by the American Medical Association Council on Medical Education and Hospitals etc."

CHAPTER XI—COMPONENT SOCIETIES, Section 3, Membership.

Amend Subsection 1, Qualifications and Requirements, as follows:

"1. QUALIFICATIONS AND REQUIREMENTS.—Each component medical society shall establish its requirements for membership and shall judge the qualifications of its applicants. EACH COUNTY MEDICAL SOCIETY WITHIN WHOSE JURISDICTION AN APPROVED MEDICAL SCHOOL OR COLLEGE EXISTS SHALL MAKE PROVISION FOR ADMISSION OF MEDICAL STUDENTS TO MEMBERSHIP AND IT SHALL BE THE SOLE AUTHORITY TO DETERMINE THE RIGHTS AND PRIVILEGES OF STUDENT MEMBERSHIP. Since membership in a component society is a prerequisite to membership in the Florida Medical Association and the American Medical Association, every reputable and licensed doctor of medicine in his respective county who is practicing, or who will agree to practice, non-sectarian medicine shall be privileged to apply for membership."

Privilege of the Floor

CHAPTER IV—HOUSE OF DELEGATES, Section 14—Privilege of the Floor.

Amend by adding council chairmen so that it will read:

"THE PRIVILEGE OF THE FLOOR SHALL BE RESTRICTED TO SEATED DELEGATES, OFFICERS, MEMBERS OF THE BOARD OF GOVERNORS, AMA DELEGATES, PAST PRESIDENTS, MEMBERS OF THE COUNCIL ON SPECIALTY MEDICINE, COUNCIL CHAIRMEN, AND AMA PAST PRESIDENTS WHO ARE FMA MEMBERS, EXCEPT BY PERMISSION OF THE PRESIDING OFFICER.

"THIS PRIVILEGE INCLUDES THE RIGHT TO MAKE MOTIONS, PROVIDED THEY ARE SECONDED BY A VOTING MEMBER OF THE HOUSE."

Supplemental Report Board of Governors

The Reference Committee unanimously recommended that the Supplemental Report of the Board of Governors which contains the reorganization plan of the Florida Medical Association be adopted.

The Supplemental Report of the Board of Governors was unanimously adopted.

Supplemental Report Board of Governors

JOSEPH C. VON THRON, M.D., *President*

In its annual report which was included in the Delegates handbook, your Board reported that it had requested the Executive Committee, which serves as the finance committee and long-range planning committee, to conduct an indepth review with the Executive Vice President regarding council and committee structure and functions, and to formulate recommendations for revision where necessary. This supplemental report to the House of Delegates includes extensive recommendations as unanimously approved by the Board of Governors to effect those By-Laws changes necessary to implement these recommendations. These recommendations embody abolishing certain councils and committees and transferring their functions to others. They are a serious endeavor to make the Association more flexible, efficient and result in greater effectiveness.

By-Laws Amendments

CHAPTER III—SESSIONS AND ASSEMBLIES

Section 1—Participation

Amend by deleting the words, "in consultation with the Committee on Scientific Assemblies," in the first sentence of the first paragraph.

Section 2—Medical Research

Amend by deleting the words, "the House of Delegates" in the first sentence.

CHAPTER VII—BOARD OF GOVERNORS

Section 2—Duties and Functions

Amend by adding No. 11 and 12 after Item No. 10 as follows:

11. THE BOARD SHALL MAINTAIN STANDING COMMITTEES OF:
    1. AMA DELEGATES
    2. BOARD OF PAST PRESIDENTS
12. THE BOARD SHALL MAINTAIN STANDING COMMITTEES FOR:
    1. ALLIED HEALTH PROFESSIONS
    2. VOLUNTARY HEALTH AGENCIES
    3. COUNTY MEDICAL SOCIETY PRESIDENTS

CHAPTER VIII—COUNCILS

Amend Chapter VIII to read as follows:

Section 1. Organization

Directly responsible to and reporting through the Executive Committee to the Board of Governors shall be the following Councils:

1. Judicial
2. Legislation and REGULATIONS
3. Medical Economics
4. Medical Services
5. MEDICAL SYSTEMS
6. Scientific Activities
7. Specialty Medicine

Section 2. Composition, Selection and Appointment to Fill Vacancy

Unless otherwise provided in these By-Laws, each Council shall be composed OF COMMITTEES IN NUMBER AND SIZE AS DETERMINED BY THE BOARD OF GOVERNORS.

The President shall appoint annually a chairman and a vice chairman when indicated of each Council.

Section 3. Duties, Functions, AND COMPOSITION

In general, the duties and functions of each Council shall be:

Each Council shall ACT AS A COMMITTEE AS A WHOLE OR coordinate, direct and supervise the several Committees of which it is composed. It shall receive instructions and directives from the Executive Committee and the Board of Governors, and shall make assignments to the appropriate Committees. It shall receive reports from its Committee Chairmen as required and shall include the annual reports of the respective Chairmen in its annual report to the Executive Committee. In addition, each Council shall encourage and aid its Committees in planning and procedures. It may initiate ideas and projects for consideration by the Executive Committee. It shall meet at least once annually on call by its Chairman.

The duties and functions of each Council shall be, DETERMINED BY THE BOARD OF GOVERNORS BUT WILL BE GENERALLY AS FOLLOWS:

1. The Judicial Council shall consist of five members elected by the House of Delegates upon having first been nominated by the Board of Governors, one from each of the four medical districts and one from the state at large, on a staggered basis so that one member's term expires each year, and thereafter for five year terms each. The House of Delegates may reject a nominee but may not initiate the nomination. To be eligible for nomination for election to the Judicial Council, a member must have been a member of the Florida Medical Association for at least ten years, and his nomination must have the concurrence of the county medical society in which he holds membership. No member may serve on the Judicial Council for more than two consecutive five-year terms.

The Judicial Council shall direct and supervise the activities of the Association which pertain to questions of medical ethics, dissension and disputes referred to the Association for investigation and adjudication, complaints by patients against members of the Association and questions of membership and disciplinary action. In the carrying out of these activities, it shall have the same authority as other councils to delegate and refer matters to the committees under it for consideration and recommendations, except that the chairmen of these committees shall not be members of the Council unless so elected by the House of Delegates. The Council shall receive reports and recommendations from its committees and shall in turn report their activities to the Board of Governors.

The President shall annually designate one of the elected members of the Council as its chairman; one as its vice chairman; and one as the chairman of the Committee on Membership and Discipline. The Council shall from among its members designate one member to serve: as liaison with the State Board of Medical Examiners for licensure policies and procedures; to assume responsibility for handling complaints and grievances received from the general public against members of the Association; TO ASSUME THE RESPONSIBILITY REGARDING QUACKERY; TO SERVE AS LIAISON WITH OSTEOPATHIC PHYSICIANS; RESPONSIBILITY FOR MEDICINE AND RELIGION PROGRAMS. Members so selected by the Council shall report regularly to the full Council, and the Council in turn shall report regularly to the Board of Governors through the Executive Committee.

2. The Council on Legislation and REGULATIONS shall direct and supervise the activities of the Association which pertain to state and national legislation AND REGULATIONS. It shall develop and submit to the House of Delegates through prescribed channels state legislative programs. It shall devise methods to implement such approved programs. It shall assist in promoting national legislative programs sponsored by the American Medical Association and approved by the Florida Medical Association. It shall maintain liaison with officials of state and national governmental agencies, SPECIFICALLY AS IT RELATES TO LEGISLATION AND REGULATIONS. It shall report its activities regularly to the Board of Governors through the Executive Committee.

3. The Council on Medical Economics shall maintain liaison with health insurance agencies, and shall advise on industrial medicine relations and PROGRAMS of the government such as Medicare, MEDICAID, WORKMEN'S COMPENSATION, VOCATIONAL REHABILITATION and veterans' medical services. It shall serve as a clearing house on fee schedules and other questions affecting the economics of medicine. It shall report its activities regularly to the Board of Governors through the Executive Committee.

4. The Council on Medical Services shall direct and supervise the activities of the Association which normally are classified as medical services SUCH AS PUBLIC HEALTH, RURAL HEALTH, SCHOOL HEALTH, EMERGENCY MEDICAL SERVICES, AND DRUG ABUSE. It shall report its activities regularly to the Board of Governors through the Executive Committee.

5. THE COUNCIL ON MEDICAL SYSTEMS SHALL MAINTAIN LIAISON WITH FOUNDATIONS FOR MEDICAL CARE, PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, PEER MEDICAL UTILIZATION REVIEW, HOSPITALS AND EXTENDED CARE FACILITIES, AND OTHER GOVERNMENT PROGRAMS. IT SHALL REPORT ITS ACTIVITIES REGULARLY TO THE BOARD OF GOVERNORS THROUGH THE EXECUTIVE COMMITTEE.

FMA Executive Vice President W. Harold Parham, with wife Mary at his side, appears to be involved in a discussion with someone across the table.

6. The Council on Scientific Activities shall direct and supervise activities of the Association which pertain to The Journal and other scientific publications, the schedule and program of all Association meetings, CONTINUING MEDICAL education, and all scientific research as directed by the House of Delegates or the Board of Governors. It shall direct and supervise those activities of the Association which pertain to medical education in medical schools and hospitals. It shall study and investigate any aspect of medical school activities and intern and resident training, and it shall submit recommendations to the Executive Committee. It shall maintain liaison with all recognized medical schools in the State of Florida. It shall report its activities regularly to the Board of Governors through the Executive Committee.

7. The Council on Specialty Medicine shall provide representation of all specialty organizations within the FMA and shall maintain liaison with and serve in an advisory capacity to all recognized specialty groups and the Board of Governors of FMA. It shall consider all matters referred to it by the House of Delegates, Board of Governors, Executive Committee, or president of FMA, and shall provide harmony and cohesiveness to the general body of medicine in Florida. It shall report its activities regularly to the Board of Governors.

CHAPTER IX—COMMITTEES

Amend Chapter IX to read as follows:

Section 1—Organization

Directly responsible to and reporting through their respective Councils shall be the following Standing Committees of the Association.

The Judicial Council: Committee on Membership and Discipline. This Committee shall be composed of four members of the Association from each Congressional District, elected for four year terms on a staggered basis by the House of Delegates annually from a slate of nominees presented by the Board of Governors and any additional nominations made from the floor.

The Council on Legislation and REGULATIONS: Committees on National Legislation and State Legislation. The Committee ON NATIONAL LEGISLATION shall be composed of a Key Contact Physician from each Congressional District in the State, one for each United States Senator from Florida and a chairman. The members shall be selected annually by the Board of Governors. The Chairman shall be appointed by the President.

The Council on Specialty Medicine: The Council on Specialty Medicine shall be composed of one representative from each specialty organization in the State of Florida officially recognized by the FMA. Recognition of a Florida Specialty Group by the FMA shall automatically entitle the recognized group to representation on this Council.

Each representative on the Council on Specialty Medicine shall be elected annually by the Specialty Group which he represents, and may be re-elected to as many terms as the represented organization so desires. An alternate representative may be selected at the same time and reported along with the regularly elected representative.

The President of the FMA shall appoint annually a chairman of the Council.

Board of Past Presidents—This Committee shall be composed of all living Past Presidents. The Chairman shall be selected by the Committee from among its membership. The Board of Past Presidents shall comprise a special standing committee of the Board of Governors, responsible directly to the Executive Committee and the Board of Governors.

Voluntary Health Agencies—THIS Committee OF THE BOARD shall PROVIDE LIAISON, ANNUAL REVIEW, AND EVALUATION OF each voluntary health agency operating within the State and recognized by the Board of Governors.

Section 2—Composition, Selection and Tenure of Committees

Special Committees for specific purposes may be established by the Board of Governors or the House of Delegates. These Committees shall be Subcommittees to the Board of Governors and shall be appointed by the President subject to approval by the Board. The number and qualifications of the members of the Subcommittees shall be determined by the particular requirement of the project. A Subcommittee shall be automatically terminated upon completion of its assignment and may be terminated at any time by majority vote of the originating body.

Section 3—Duties and Functions

The general duties and functions FOR all Committees SHALL BE DETERMINED BY THE BOARD OF GOVERNORS unless provided otherwise in these By-Laws. Each Committee shall be responsible for activities and projects in the appropriate field as assigned to it. Committee Chairmen or members shall not obligate the Association for funds except as expressly authorized by the Board of Governors.

The specific duties and functions shall be:

1. The Committee on Relative Value Studies shall be responsible for the study, development, modification, and necessary negotiations of relative value studies or fee schedules accepted or endorsed by the Association. It shall consult with other appropriate Committees and with the Council on Specialty Medicine.

2. The Committee on Scientific Publications shall direct and supervise the publication of The Journal of the Florida Medical Association. It shall be responsible for the establishment of editorial policies and procedures, provided they are not in conflict with or do not abrogate any section of these By-Laws or any directive of the House of Delegates or the Board of Governors. It shall also be responsible for the selection of scientific articles for publication and the preparation of editorials for publication. In addition, this Committee shall set advertising standards for advertising in The Journal of the Florida Medical Association and its other publications and shall pass on requests for space or advertising copy not previously approved by the State Journal Advertising Bureau or similar approving agency.

3. The Committee on Membership and Discipline shall from time to time review membership classifications and make recommendations. It shall receive from the Judicial Council reports of disputes between members, between a member and his component society, between a member and the Association, between component societies, and between a component society and the Association. It shall investigate these reports and make recommendations to the Chairman of the Judicial Council as to disposition. In addition, it shall receive, study and investigate all matters pertaining to medical ethics and shall make recommendations to the Chairman of the Judicial Council. It shall also serve as the Committee to investigate complaints regarding medical testimony.

4. The Council on Specialty Medicine shall serve in an advisory capacity to the Committee on Relative Value Studies in the development or modification of fee schedules accepted or endorsed by the Association.

It shall ASSIST with the Council on Scientific Activities in coordinating meetings held at the time of the Association's Annual Meeting.

Report of Board of Governors' Representative from the State Board of Medical Examiners

Upon recommendation of the Reference Committee, the Report of the Board of Governors' Representative from the Florida State Board of Medical Examiners was filed for information.

Florida Medical Foundation

Upon recommendation of the Reference Committee the Report of the Florida Medical Foundation was filed for information.

Subcommittee on Quackery

Upon recommendation of the Reference Committee the Report of Subcommittee on Quackery was filed for information.

Florida Physicians Association, Inc.

Upon recommendation of the Reference Committee the Report of Florida Physicians Association, Inc. was filed for information.

Judicial Council

Upon recommendation of the Reference Committee Recommendations No. 1 and No. 2 of the Judicial Council were adopted as presented.

The Reference Committee unanimously recommended that the Report of the Judicial Council be adopted as printed in the Handbook.

The Report was adopted as printed.

Judicial Council

VINCENT P. CORSO, M.D., *Chairman*

Drafting statewide standards for paid professional newspaper announcements and telephone directory listings and writing by-laws amendments to permit medical students to become members of the Florida Medical Association have been among major accomplishments of the Judicial Council in 1973-74.

In the meantime, your Council has continued its series of regional conferences on membership, discipline, ethics, etc., and has continued its efforts to maintain cooperation and rapport between the Florida Medical Association and the Florida State Board of Medical Examiners.

Since the last Annual Meeting, your Council or its representatives, mainly the Membership and Discipline Committee, has conducted a number of investigations involving members of the Association and their adversaries. In addition, the Council has ruled on several questions of ethics put to it, a summary of which appears elsewhere in this report.

Your Council had scheduled four meetings during this reporting period. However, the February, 1974 meeting was cancelled for several reasons, including the national energy crisis. Meetings were held June 30 and July 1, 1973, at Bal Harbour; September 22-23, 1973, at Tallahassee; and December 15-16, 1973, at Tampa. An accounting of the major activities of the Council follows.

FMA Membership for Medical Students: In 1973, the Judicial Council and the Council on Scientific Activities presented reports on the proposal that certain medical students be allowed to become members of FMA. These reports were in disagreement on several important points, and it was suggested to both Councils that they try to reach agreement on these differences. They did, and a joint report which had the unanimous endorsement of both Councils was submitted at the October, 1973 meeting of the Board of Governors (see Report of the Board of Governors).

Statewide Standards for Paid Professional Newspaper Announcements and for Telephone Directory Listings: As directed by the Board of Governors, the Council spent considerable time on the matters of possibly invoking statewide standards or guidelines for paid newspaper announcements by physicians and for physicians' telephone directory listings. A state-level mandate in these two areas would be a departure from tradition which has been to leave such determination up to the individual county medical societies. Your Council, in its report to the Board of Governors on these two subjects, had no recommendation with regard to the basic principle, but did observe that three options are available: (1) maintain the status quo; (2) adopt statewide standards to be applied absolutely and uniformly throughout Florida; and (3) adopt standards to be adopted by county medical societies on an optional basis. The Council submitted guidelines or standards that could be applied in the event either of the latter two options were chosen.

Regional Membership and Discipline Conferences: In cooperation with the Florida State Board of Medical Examiners, the Council sponsored the Third and Fourth Regional District Conferences of the Membership and Discipline Committee and County Medical Society Chairmen of Grievances, Ethics, Discipline and Censors. These were conducted in Tallahassee (September) and in Tampa (December). While the attendance at the Tallahassee meeting was disappointing, your Council believes that this series has been worthwhile and that more sessions should be held in the future.

The Committee on Scientific Publications has graciously offered—and the Council has accepted—to publish a special Medical Ethics issue of *The Journal of the Florida Medical Association* during 1974. This issue will include papers presented at this series of regional conferences.

Joint Meeting with Florida Board of Medical Examiners: On July 1, 1973, your Council had its second annual joint meeting with the Board of Medical Examiners. Several topics of mutual concern were discussed. These include: (1) implementation of the temporary medical licensure law that went into effect on October 1, 1973 (see below); (2) the Board's rule on ear piercing by non-physicians; (3) the Board's rule on insurance and pre-employment physical examinations conducted by paramedical personnel; (4) unlicensed physicians; (5) certification of physician's assistants; and (6) cases referred to both the Council and the BME by the Committee on Peer Medical Utilization Review.

Your Council believes that a productive working relationship has been established between the Florida Medical Association and the Board of Medical Examiners. For its part, the Council plans to continue its meetings with the Board on at least an annual basis.

Use of Physician's Name in Commercial Advertising: On April 28, 1973, the Judicial Council of the American

AMA President-Elect Malcolm C. Todd, M.D. (right) was a surprise guest speaker at the Annual Meeting. Here, he prepares to present, on behalf of AMA, a plaque commemorating FMA's 100th Anniversary, to FMA President Joseph C. Von Thron, M.D.

Medical Association adopted a statement entitled "Use of Physician's Name in Commercial Advertising." The crux of this statement is contained in the following paragraph:

"It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises."

The FMA Judicial Council concurred in this statement, which was published in its entirety in an issue of *The Journal of the Florida Medical Association*. Your Council has applied this ethic in at least two cases brought to its attention this year.

Damon Coporation: Currently under investigation by the Council is the acquisition of a Florida radiological practice by the Damon Corporation. Various documents related to the acquisition have been reviewed and one of the principal physicians involved has been interviewed. However, up to this point, the Council has reached no definite conclusion with regard to this matter.

Temporary Licensure Law: In 1973, the Legislature enacted an amendment to the Medical Practice Act which authorizes the Board of Medical Examiners to issue temporary licenses, without written examination, to certain out-of-state physicians who will practice medicine in those communities of 7,500 population or less that are designated by the BME as areas of physician shortage. It is possible that the Council will become involved with the implementation of this law through the Membership and Discipline Committee. Although no plans have been finalized, it is possible that members of the Committee will be asked to screen applicants for temporary licenses and assess their suitability.

Compensation for Membership and Discipline Committee: The Membership and Discipline Committee has two basic roles. First, it is a standing committee of the Judicial Council and its members conduct investigations and perform other duties as directed by the Council. Secondly, the Membership and Discipline Committee members are sworn deputy investigators for the Board of Medical Examiners. Both roles have been expanding and likely will continue to expand. Your Council has recommended to the Board of Governors that it propose to the Board of Medical Examiners that provisions be made for compensation of the members of the Membership and Discipline Committee when on state business.

County Medical Societies: The Council has submitted a recommendation to the Board of Governors and House of Delegates that Levy County be transferred from the geographical area of jurisdiction of the Marion County Medical Society to that of the Alachua County Medical Society. The three FMA members residing in Levy County are members of Alachua (see Board of Governors Report).

Journal Advertising: The Council has under consideration a request from the editors of *The Journal of the Florida Medical Association* for advice as to advertising policy. One question in particular that the Council is deliberating is whether it is ethical for the names of physicians to be listed in the display advertising of related facilities.

Ear Piercing: A Board of Medical Examiners rule on ear piercing by non-physicians has ignited a dispute as to whether the Board may make certain determinations under the Medical Practice Act. In substance, the Board has held that such ear piercing must have some degree of medical supervision and system of referral of patients who develop complications. A state attorney has questioned whether the Board of Medical Examiners has the authority to regulate ear piercing under the Medical Practice Act; and he has requested an opinion from the Attorney General on this. Your Council has urged the Board of Governors to take whatever action is necessary to defend the traditional and rightful responsibility of the Board of Medical Examiners to determine what constitutes the practice of medicine.

Osteopathy: Under the provisions of Resolution 70-4, the Council reviewed and approved an amendment to the Broward County Medical Association's policy on osteopathy.

University of South Florida Private Practice Plan: The Council reviewed and approved various documents related to the University of South Florida College of Medicine's private practice plan.

Rulings of the Council: During the year, the Council was asked to rule on a variety of questions which had ethical ramifications. These were submitted by county medical societies, individual physicians and others. Some of these cases had both legal and ethical facets and the advice of FMA's legal counsel was sought.

Grievances and Complaints: During the year, the Council assigned to the appropriate county medical societies for investigation complaints received from the public against member physicians. For the most part, these were acted upon promptly to the apparent satisfaction of the complainant. Some decisions were appealed to the Judicial Council.

Proposed New County Medical Societies: The Judicial Council has reviewed a petition for a new county medical society signed by 17 physicians residing and/or practicing in Pasco County. Under the provisions of Chapter XI (Component Societies) of the Florida Medical Association By-laws, your Council makes the following recommendation.

Sexologist William Masters, M.D., of St. Louis, proved to be one of the biggest drawing cards of recent FMA meetings. Here, he addresses a standing-room-only audience on everyone's favorite subject.

RECOMMENDATION

1. That the House of Delegates grant a Florida Medical Association Charter to the proposed Pasco County Medical Society; that the existing Pasco-Hernando-Citrus County Medical Society be rechartered to reflect the removal of Pasco County; and further, that these actions be made contingent upon approval by the Judicial Council of county medical society bylaws to be submitted by the Pasco County Medical Society.

The following recommendation is also made under the provisions of Chapter XI (Component Societies) of the FMA Bylaws and is made on the basis of a petition signed by six Flagler County physicians seeking an FMA Charter for a new Flagler County Medical Society.

RECOMMENDATION

2. That the House of Delegates grant a Charter to the proposed Flagler County Medical Society; that the St. Johns County Medical Society be rechartered to reflect the removal of Flagler County from its area of jurisdication; and further, that this action be made contingent upon approval by the Judicial Council of bylaws to be submitted by the Flagler County Medical Society.

Supplemental Report
Judicial Council

Upon recommendation of the Reference Committee the Supplemental Report of the Judicial Council was filed for information.

Council on Specialty Medicine

Upon recommendation of the Reference Committee the section of the Report of the Council on Specialty Medicine pertaining to Specialty Group Recognition was filed for information.

Council on Medical Services

Upon recommendation of the Reference Committee, Recommendation No. 10 of the Report of Council on Medical Services was adopted as printed.

(See Council on Medical Services Report, page 525).

Resolution 74-1
FMA Headquarters Location
Broward County Medical Association

Upon recommendation of the Reference Committee, Resolution 74-1 was not adopted.

Resolution 74-3
Intra-Association Communication
Sarasota County Medical Society

Upon recommendation of the Reference Committee, Resolution 74-3 was not adopted.

Resolution 74-14
FMA Secretary-Treasurer
Broward County Medical Association

Upon recommendation of the Reference Committee, Resolution 74-14 was not adopted.

Resolution 74-22
Representation on FMA Board of Governors
Hillsborough County Medical Association

The Reference Committee unanimously recommended that Resolution 74-22 be referred to the Board of Governors for indepth study and with a report to be submitted to the House of Delegates at the Annual Meeting in 1975.

Resolution 74-22 was referred to the Board of Governors.

Resolution 74-22

Representation on FMA Board of Governors

[Not Adopted—Referred to Board of Governors]

Whereas, The Board of Governors of the Florida Medical Association was constituted over 25 years ago with four Medical Districts and this number has never changed, and

Whereas, The rapid growth of Florida and of the Florida Medical Association membership has resulted in repeated failure to give certain geographical areas equitable or proper representation and far too many locales and physicians are without any representation at all, and

Whereas, Information from the American Medical Association, Florida Medical Association and the Board of Governors is often received by county medical societies in meager fashion and is sometimes slow in arriving, which often precludes proper consideration or action by the component county medical societies, therefore, be it

RESOLVED, That in order to truly represent the entire State of Florida the membership of the Board of Governors of the Florida Medical Association be increased to afford at least the twelve designated Florida Department of Administration areas one representative so that the membership as a whole can feel they have adequate representation on the Board of Governors, and be it further

RESOLVED, That the membership of the Executive Committee likewise be increased to take into account the geographical areas of the state.

Resolution 74-25
Osteopathy
Duval County Medical Society

The Reference Committee recommended that Resolution 74-25 be amended by deleting, in the RESOLVED, the words "qualified osteopathic physicians" and substituting the words "osteo-

pathic physicians as members who are deemed to be qualified and who have also completed AMA approved internships and/or resident training programs."

A motion was made from the floor to amend the amendment by moving the words, "as members" to follow the word "accept" which would read, ". . . societies to accept osteopathic physicians who are deemed . . ."

The motion carried.

The motion was made from the floor to strike the amendment. This motion was ruled out of order, there was discussion, and the question was called on the amendment as recommended by the Reference Committee and amended by the House.

The vote was taken, but it was necessary for the Chair to call for a division of the house.

The motion to amend Resolution 74-25 as recommended by the Reference Committee and amended by the House was defeated by a vote of 88 to 83.

A motion was made from the floor to amend the original Resolution 74-25 by deleting the word "qualified" in the RESOLVED, and adding the words, "deemed to be qualified" between the words "osteopathic physicians" and "in their respective."

The motion carried to amend Resolution 74-25.

The motion was made to refer Resolution 74-25 to the Board of Governors. This motion was seconded.

A motion was made from the floor to table Resolution 74-25, Osteopathy, as amended. The Chair informed the House that a motion to table does supersede a motion to refer and requires a second but no discussion is allowed. The motion was seconded.

A vote was taken but members of the House called for a standing vote also.

The motion to table Resolution 74-25, Osteopathy, as amended, carried.

Resolution 74-33
Examination for Florida Licensure
Dade County Medical Association

The Reference Committee listened to testimony which indicated that a meeting between representatives of the South Florida Psychiatric Society and the Florida State Board of Medical Examiners is scheduled for July, 1974. The Reference Committee believes that this meeting should be encouraged and subsequent meetings if necessary and believes that the Board of Governors would have continuing interest in this complex subject. For this reason, the Reference Committee recommends that Resolution 74-33 be referred to the Board of Governors.

Resolution 74-33, Examination for Florida Licensure, was referred to the Board of Governors.

Resolution 74-33

Examination for Florida Licensure

[Not Adopted—Referred to the Board of Governors]

Whereas, The Application for Examination for Licensure of the Florida State Board of Medical Examiners includes certain discriminatory questions relating to mental health and psychotherapy, and

Whereas, These questions have caused consternation and concern among psychiatrists, applicants for examination and medical students, and

Whereas, Medical Students are encouraged to consult psychiatrists for personal and emotional problems in order to better qualify them for the practice of medicine, and

Whereas, These certain questions present what is viewed as an obstacle to such consultations and prejudices the applicant who has sought such consultation, and

Whereas, These certain questions tend to violate the confidential relationship between psychiatrist and patient, now therefore be it

RESOLVED, The Florida Medical Association petitions the Board of Medical Examiners to delete the certain questions from the Application for Examination, and further

RESOLVED, Since the Association recognizes and is in complete accord with the highly commendable objectives of the Board of Medical Examiners, namely, the licensing of only well-qualified practitioners, the South Florida Psychiatric Society has freely offered its aid and would be most pleased to work with the Board in attaining this objective.

Dr. Daughtry: "Your Chairman wishes to thank the members of this committee, Doctors Yank D. Coble Jr.; Frank C. Coleman; Robert C. Seelman; and William Davenport and the members of the FMA who came to speak before the committee."

"We also wish to express our thanks to our able secretary, Mrs. Neel, of the FMA Staff, for her very capable assistance."

"Mr. Speaker, the Reference Committee recommends that the Report of Reference Committee No. III be adopted as amended."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. III."

The Speaker, Dr. Evans announced that Reference Committee Reports No. IV and V would be considered at the Third House of Delegates on Sunday. He then turned the chair over to the President, Dr. Von Thron for the installation ceremony.

Installation of the President

Dr. Von Thron indicated that the reason for changing from the usual procedures is that he thought this would afford the proper dignity to the incoming President. Dr. Von Thron commented on the many physicians who have assisted him over the past year and paid them tribute for their fine work and assistance. Dr. Von Thron stated that there were three reasons why he was sure that the Florida Medical Association will do well next year—(1) because of the fabulous group in the membership, (2) because of Dr. Parham, and (3) because of the man who is going to be taking the gavel from him in a moment.

Dr. Von Thron presented the President's Gavel and the President's Plaque to Dr. Moseley.

Dr. Moseley very graciously accepted the Gavel and requested that Jim and John Von Thron bring their Mother to the podium where he presented Dr. Von Thron's portrait and a pendant to her.

Dr. Moseley presented the past president's pin to Dr. Von Thron.

Dr. Moseley urged everyone to get involved. He discussed the various committees he will establish to carry out the business of the Association and outlined his plans for the coming year. Dr. Moseley closed by stating, "I hope I will serve you as you wish as your President, I know I will do my best, and thank you for allowing me to have this privilege."

Dr. Moseley then requested his son, Thad, and his wife's father to escort his wife forward for recognition and for his daughter, Stacy, and their good friend, Mr. Richard Stein, to come forward also.

Dr. Evans, Speaker of the House, assumed the chair and called for a motion to recess.

The speaker announced that the House would recess until Sunday morning at 9:00 a.m.

The Second Meeting of the House of Delegates recessed at 5:58 p.m.

Outgoing President Joseph C. Von Thron (right) presents the president's certificate and gavel to his successor, Thad Moseley, M.D., Jacksonville.

Incoming President Thad Moseley, M.D., Jacksonville, presents a portrait of retiring President Joseph C. Von Thron, M.D., to Mrs. Von Thron. Looking on are Dr. Von Thron's two sons.

Incoming President Thad Moseley, M.D., fastens the past president's pin on the lapel of Joseph C. Von Thron, M.D.

Third House of Delegates

The third meeting of the House of Delegates convened at 9:05 a.m. on Sunday, May 12, 1974, in the Regency Room North of the Diplomat Hotel in Hollywood, Florida, with Dr. Franklin J. Evans, Speaker of the House, presiding.

Dr. Benson, Chairman of the Credentials Committee, reported 192 delegates registered, constituting a quorum and more than half the counties were represented.

Dr. Benson moved that the delegates be seated.

The motion carried.

Delegates

ALACHUA—Stanley I. Cullen, David M. Drylie, Charles H. Gilliland, George H. Miller Jr., Gerold L. Schiebler (Absent—Henry J. Babers Jr.).
BAY—(Absent—James D. Nixon, Owen Reese Jr.).
BREVARD—Lewis A. Bean, John T. Blackburn, James E. Carter, T. John Kaminski, Robert C. Seelman.
BROWARD—Robert J. Brennan, Andre S. Capi, M. P. Caster, Fred G. Gieseke, James A. Jordan, David C. Lane, Jerry D. Moore, Ray E. Murphy Jr., F. B. Ott, Henry D. Perry Jr., James B. Perry, Thomas F. Regan, Diran M. Seropian, N. J. Skaja, Daniel S. Smith, W. D. Wells (Absent—R. B. Carson, T. W. Hahn, William B. King, George P. Messenger.
CAPITAL—Robert P. Johnson, N. H. Kraeft, Robert N. Webster (Absent—Jack W. MacDonald).
CHARLOTTE—Melvyn J. Katzen, Fred P. Swing.
CLAY—Laurin G. Smith III.
COLLIER—William J. Bailey (Absent—Fred A. Butler).
COLUMBIA—(Absent—Barnie L. Vanzant).
DADE—Pedro Arroyo, William Aten, Jerome Benson, Morris Blau, Rufus K. Broadaway, Sol Center, Richard C. Clay, Jack Q. Cleveland, Vincent P. Corso, DeWitt C. Daughtry, O. William Davenport, Joseph Davis, Richard C. Dever, Robert Dickey, J. Lee Dockery, Charles Dunn, Miguel Figueroa, Joseph Fitzgerald, Ivor Fix, Richard M. Fleming, Pedro Greer, Julian Groff, Marshall Hall, David Hallstrand, Henry Hardin, Joseph Harris, James Hutson, Walter Jones Jr., Walter Jones III, Banning G. Lary, Maurice H. Laszlo, Carlos Llanes, Rose London, Ronald Mann, Charles A. Monnin, Ed Preston, Walter W. Sackett Jr., Edward W. St. Mary, Robert Schiess, Daniel Seckinger, Janice Sherwood, Everett Shocket, Ruth A. R. Simons, Chauncey M. Stone Jr., Mario Stone, William Straight, John Turner, Stanley Wharton, Robert E. Willner, Art Wood, Sheldon Zane (Absent—Manuel Carbonell).
DESOTO-HARDEE-GLADES—Calvin W. Martin.
DUVAL—Warren M. Barrett, Yank D. Coble Jr., Joe C. Ebbinghouse, Emmet F. Ferguson Jr., William J. Garoni Jr., Stephen P. Gyland, William T. Haeck, John C. Kruse, Charles B. McIntosh, Faris S. Monsour, Sanford A. Mullen, John A. Rush Jr. (Absent—James L. Borland Jr., Richard T. Donelan, Donald R. Hagel).
ESCAMBIA—Charles J. Kahn, Philip B. Phillips, F. Norman Vickers, William M. C. Wilhoit, Henry M. Yonge.
FRANKLIN-GULF—(Absent—Joseph P. Hendrix).
HIGHLANDS—Donald C. Hartwell.
HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Richard G. Connar, Irvin M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Victor H. Knight Jr., Joel W. Mattison, Thomas E. McKell, William W. Trice, Harold L. Williamson (Absent—Richard S. Hodes).
INDIAN RIVER—James C. Robertson (Absent—Paul W. Taylor)
LAKE—Bergon F. Brokaw, Thomas D. Weaver.
LEE—Larry P. Garrett, J. Stewart Hagen III, F. Lee Howington.
MADISON—(Absent—William J. Bibb).
MANATEE—John D. Lehman, Roger A. Meyer, M. P. Quillian.
MARION—H. L. Harrell, C. B. Henderson.
MARTIN—(Absent—John Powers).
MONROE—John Buckner, Ronald H. Chase.
NASSAU—Marshall E. Groover.
OKALOOSA—William W. Thompson.
ORANGE—Norman F. Coulter, Francis M. Coy, William F. Eckbert Jr., Clarence M. Gilbert, Paul C. Harding, Joseph G. Matthews, Richard L. Parker Jr., James F. Richards Jr., Edward W. Stoner, Thomas B. Thames, Robert B. Trumbo (Absent—G. Brock Magruder).
OSCEOLA—George A. Gant.
PALM BEACH—Willard F. Ande, Carl E. Andrews, Vernon B. Astler, Curtis W. Cannon, Jerry F. Cox, George L. Ford Jr., J. Russell Forlaw, Bernard Kimmel, Richard B. Moore, Dick L. Van Eldik, Howard Willson.
PANHANDLE—H. E. Brooks.
PASCO-HERNANDO-CITRUS—James P. Gills Jr., W. Randall Jenkins.
PINELLAS—Charles K. Donegan, Irwin L. Entel, James C. Fleming, John M. Hamilton, Daniel S. Hellman, David S. Hubbell, Roger A. Laughlin, Jack A. MaCris, Donald G. Nikolaus, David T. Overbey, Richard C. Trump, Walter H. Winchester, Rowland E. Wood.
POLK—Marvin G. Burdette, Thomas M. Caswall, J. G. Converse, Howard M. Dubose, John W. Glotfelty, W. E. Manry, Paul A. Tanner.
PUTNAM—C. E. Barrineau.
ST. JOHNS—William W. O'Connell.
ST. LUCIE-OKEECHOBEE—H. C. McDermid.
SANTA ROSA—(Absent—William N. Watson).
SARASOTA—John N. Carlson, David A. Giordano, Franklin H. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.
SEMINOLE—Luis M. Perez.
SUWANNEE-HAMILTON-LAFAYETTE—Hugo F. Sotolongo.
TAYLOR—(Absent—J. H. Parker Jr.).
VOLUSIA—Thomas W. Ayres, James A. Carratt, William H. Harrison Jr., Charles A. Stump, Thomas L. Wells.
WALTON—(Absent—Howard F. Currie).
SPEAKER OF THE HOUSE—Franklin J. Evans.
VICE SPEAKER OF THE HOUSE—Louis C. Murray.

The Speaker introduced Senator David C. Lane, M.D. of Broward County. Dr. Evans explained that Senator Lane was the only physician in the Florida Senate.

Dr. Evans stated that one man who works quietly, efficiently, and keeps you posted on all the happenings in the legislature and deserves a lot of commendation and recognition is Scotty Fraser of the Capital Office.

Dr. Leo Wachtel, a past president, was asked to come forward for a memorial service.

Dr. Wachtel presented the following memorial resolution and asked that the House recognize the passing of John D. Milton, M.D. by standing for a moment of silent meditation.

MEMORIAL RESOLUTION
JOHN D. MILTON, M.D.

Whereas, John D. Milton, M.D., the 78th President of the Florida Medical Association, spent almost a half century serving humanity through medicine; and

Whereas, Dr. Milton was the first professor and chairman of the Department of Obstetrics and Gynecology at the University of Miami School of Medicine; and

Whereas, Dr. Milton served organized medicine in Florida as President of the Dade County Medical Association, a member of the Board of Governors of the Florida Medical Association, and ultimately as President of FMA (1955-56);

Whereas, He gave guidance to such national and regional medical organizations as the American Board of Obstetrics and Gynecology, the Southern Medical Association, the American Medical Association, and various surgical societies; and

Whereas, Dr. Milton died on August 16, 1973, at the age of 75; therefore be it

RESOLVED, That the Florida Medical Association House of Delegates, in 100th Convention assembled, notes with sadness the passing of John D. Milton, M.D., a leader who played a significant role in the growth and history of the Association; and be it further

RESOLVED, That a copy of this resolution be sent to Dr. Milton's widow.

Dr. Evans stated that since it was Mother's Day that it was only fitting that special wishes should be extended to all the Mothers. There was a round of applause.

Dr. Walter Sackett asked to be recognized and discussed the Medical Clinic in Tallahassee. He invited the physicians to come to Tallahassee and sit in on a session of the legislature and to visit the clinic, possibly serving as a "Doctor of the Day."

Dr. James W. Walker, Secretary-Treasurer, was called upon to come forward to make special award presentations.

Dr. Walker recognized Mrs. Eugene G. Peek for her outstanding efforts in selling over $14,000 worth of the auxiliary cookbook.

Dr. Walker announced the following winners of the golf tournament:

Low Net Division: Dr. P. B. Unger of Melbourne

Low Gross Division: Dr. Edmund Ackell of Gainesville

Dr. Walker announced that the Low Net trophy is given by the Duval County Medical Society and that the Low Gross trophy is given by the Dade County Medical Association.

Dr. Evans stated that no results had been received on the fishing and tennis tournaments.

Report of AMA Delegates Reference Committee

Dr. Francis T. Holland was called upon to present the Reference Committee Report of the AMA Delegates.

Dr. Holland's report was received as information.

Reference Committee Report AMA Delegates

FRANCIS T. HOLLAND, M.D., *Chairman*

Your AMA Delegates met at 9 a.m. in the Tack Room with all delegates and alternates. Also, we had Dr. Jere Annis, a member of the Board of Trustees of the AMA from Florida, and Mr. Whalen Strobhar, Director of the Public Affairs Department of the AMA. Dr. Malcolm Todd, President-Elect, regretted that he had to leave prior to this time.

We are happy to report that we had approximately twenty members in attendance. This representing approximately a 2,000% increase over last year, and your delegates now have no question in their minds but that this should be continued.

Those present were informed and articulate in their presentation. They all had valid concerns as to what is happening to American medicine.

We were appalled to learn that doctors do not know that each of you have a mechanism to take your grievances and gripes to the AMA.

1. If you have an idea that you feel should be taken to the AMA, you can present it to your county medical society and if they in turn agree with you, it will be presented to this House of Delegates and if it passes this House we are mandated to take it to the AMA and present and fight for this both in reference committee and on the floor of the House, whether we individually or collectively agree or disagree with the resolution. This we have done on several occasions.

You also have the right, whether you are a delegate or not, to appear before the reference committee of your Association and also before the reference committee of the AMA to present your view.

2. Another route of presentation of your ideas to the AMA is to present them to your specialty organization and this in turn can be presented to the House of Delegates by the delegate from that section.

3. If you have not been successful in this route, and can convince any member of the Florida delegation, they can take this and present it as an individual resolution and you still have the right to appear before a reference committee.

We would urge you to attend an AMA meeting and you may be heard at reference committees of your choice and we would welcome you to attend our caucuses.

Report of Reference Committee No. IV
Legislation and Miscellaneous

The Speaker, Dr. Evans, called for the report of Reference Committee No. IV, Legislation and Miscellaneous.

Dr. John A. Rush Jr., Chairman, and members of Reference Committee No. IV came forward to present the report of their Reference Committee.

Council on Legislation and Public Agencies

The Reference Committee noted the activities of the Committee on National Legislation and the key contact physicians, and commended them for the excellent relationship that has been developed with each member of the Florida Delegation in the U.S. Senate and the U.S. House of Representatives, including the annual congressional visit to Washington. The Reference Committee also commended the key contact physicians who work with the members of the Florida Senate and Florida House of Representatives.

The Reference Committee noted the very successful response by the "Physicians of the Day" and commended them for their participation in this program and encouraged continued publication of the Legislative Bulletin.

The Reference Committee recommended that because there seems to be an increasing amount of misdirected legislation regarding health care introduced in the Florida Legislature, the Board of Governors authorize additional personnel in the Tallahassee Office to more properly protect the interest of the citizens and physicians of Florida from this undesirable legislation.

The Chair asked for clarification as to whether this would be a mandate to the Board of Governors to increase the personnel without discretion, or a request for the Board to look into this and do it as a mattter of future business.

Dr. Rush indicated that this would not be mandatory but an encouragement to the Board of Governors to do this as it is needed.

The recommendation was adopted.

Upon recommendation of the Reference Committee the Report of the Council on Legislation and Public Agencies was adopted.

Council on Legislation and Public Agencies

SANFORD A. MULLEN, M.D., *Chairman*

Most of the work of the Council on Legislation and Public Agencies is accomplished through the activities of its three committees: Committee on State Legislation, Committee on National Legislation, and Committee on Government Programs. The report of your Council is submitted as the individual reports of the three major committees.

Committee on National Legislation—This committee consists of the key contact physicians for each member

John A. Rush Jr., M.D., Jacksonville, presides at the hearing conducted by Reference Committee IV. Others (left to right) are: Karl Rolls, M.D., Sarasota; Dick L. Van Eldik, M.D., Lake Worth; Mrs. Mary Kay Samorisky, Recorder; Robert P. Johnson, M.D., Tallahassee; and Charles A. Monnin, M.D., Coral Gables.

of the Florida Delegation in the U.S. Senate and the U.S. House of Representatives.

Members of this committee have kept in close touch with their assigned Senators and Congressmen on national legislation matters of interest to FMA and the American Medical Association.

A highlight of the committee's activities was the annual congressional visitation which was held in March in conjunction with the Annual AMA-AMPAC Public Affairs Workshop in Washington, D.C.

The committee is continuing to work with county medical societies in establishing better liaison with individual members with regard to the issue of national health insurance. It is anticipated that national health insurance legislation will pass congress during the next 12 months and the committee is actively working with AMA Washington office to inform the Florida Congressional Delegation about principle concerns of the FMA and the AMA with regard to the specific national health insurance proposals.

Committee on State Legislation—The committee has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized medical specialty groups. Three formal meetings of the committee have been held along with many informal conferences among committee members as items of an urgent nature arose. The committee is particularly pleased with the results of the Legislative Seminar, which was held as a part of the annual FMA Leadership Conference in Orlando, January 27, 1974.

Consistent with the policies developed by the FMA House of Delegates, the committee has worked closely with the Board of Governors in developing a legislative program for the 1974 Session of the Florida Legislature.

The following items summarize the committee's activities:

1. **Capital Office**—The Capital office has continued to function under the supervision of Mr. Donald S. Fraser Jr., Director of the Public Affairs Department of the FMA. Additional part-time assistance was used while the Legislature was in session, not only to assist in the operation of the Capital Office, but to provide close liaison with the physician serving as "Doctor of the Day." Increased emphasis was placed on using the resources of the Capital Office to provide better service and coordination for the various medical specialty groups.

2. **The Capitol Dispensary**—The committee has continued to place major emphasis on working with the Capitol Dispensary, which has proved to be most important in meeting the medical needs of legislators and their staffs. The critical shortage of space in the dispensary has been partially alleviated by the addition of another room. Mrs. Delma Hart, R.N., has continued to provide excellent assistance to the FMA in coordinating the activities of the dispensary with the "Doctor of the Day" program.

3. **Key Contact Physicians**—The committee on State Legislation has continued to emphasize the need to develop a good key contact physician program in each county medical society in the state. This program continues to be the cornerstone upon which a successful legislative program is built.

4. **Publications**—The Legislative Bulletin was published every week during the legislative session and periodically between sessions. The Bulletin is designed to give up-to-date information to members of the FMA who are involved in Legislative activities. A pamphlet entitled "FMA Legislative Objective—1974" was prepared by the committee, primarily for distribution to members of the Florida Legislature.

A similar publication was prepared for the 1971, 1972 and 1973 Sessions of the Legislature. The four issues of the pamphlet have been well received.

5. **1973 Legislative Accomplishments**—During the 1973 Legislative Session, there were 275 legislative proposals that required the action of the State Legislative Committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

—Equitable Funding for Florida's Title XIX (Medicaid) program;

—Passage of Legislation to protect the records of hospital and medical society review committees from discovery;

—Opposition to legislation which would require all insurance companies to cover chiropractic services in all health policies written in the State of Florida;

—Passage of legislation establishing a statewide emergency medical services system;

—Passage of legislation which would require comprehensive health education programs in all public schools in the state;

—Opposition to repeal of the antisubstitution law for prescriptions;

—Establishment of Interim study for professional liability problems.

6. **Major Legislative Objectives for 1974 Session**—The major legislative objectives for the 1974 Session of the Florida legislature as established by the FMA House of Delegates and the FMA Board of Governors were:

—Continued improvement of Florida's Title XIX (Medicaid) program, to include greater flexibility in the portions of the program that cover out patient and drug services, and the removal of burdensome administration procedures;

—Opposition to legislation which would require all insurance companies to cover chiropractic services in all policies written in the State of Florida;

—Reorganization of the state health program so that physicians are placed in a position of leadership;

—Opposition to appointment of laymen to the State Board of Medical Examiners;

—Opposition to establishment of schools of osteopathy and optometry;

—Improved funding for programs:

(a) to provide physical examinations and screening for indigent and near indigent children;

(b) Myers (Comprehensive Alcoholism Prevention, Control, and Treatment Program) and Baker Acts (Mental Health Commitment and Treatment Program);

(c) State renal disease program;

(d) Statewide medical examiners system.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA Legislative program made during the 1974 Legislation Session. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

Committee on Government Programs—The Committee on Government Programs has continued to work very closely with the Florida Department of Health and Rehabilitative Services. It is felt that the committee has been particularly helpful in establishing a close liaison with the new Secretary, Mr. Oliver J. Keller. In cooperation with other FMA Committees the Committee on Government Programs has been working with the Department of HRS to develop a peer review program for Medicaid and to improve the current operation of the program. A quarterly workshop has been established between the FMA and the Department as a means to bring about a close working relationship. As more and more of the activities with regard to health are carried out through rules and regulations adopted by the Department, it is most important that the Committee on Government Programs continue to do work closely with the state agency.

Supplemental Report
Committee on State Legislation

The Reference Committee recommended that Item 4 of the Supplemental Report of Committee on State Legislation be adopted as presented.

Item 4, Opposition to Legislation Requiring Full Disclosure of Ownership in, and Transac-

tions With, Hospitals, Labs, Optical Shops, and Other Health Facilities by Physicians (SB 464, HB 3854), was adopted as presented.

The Reference Committee recommended that action on Item 6 be deferred until a later date. The Speaker advised that it was not necessary to take an action on this.

(Oral Report SB-818 Reorganization of Dept. of HRS)

The Committee advised that in accordance with the last paragraph of the report, additional information was received on SB 818 which concerns reorganization of the Department of Health and Rehabilitative Services and recommended that a position of opposition to Senate Bill 818 in its present form be adopted.

A position of opposition to Senate Bill 818 in its present form was adopted, as recommended by the Reference Committee.

The Reference Committee commended the Committee on State Legislation and its Chairman, Sanford A. Mullen, M.D., for their tireless efforts in achieving a most successful legislative program and gave special recognition to Mr. Donald S. Frazer, Jr., Director of the Tallahassee Office, who worked so effectively toward the legislative objectives, the members of the Woman's Auxiliary and the many, many members of our Association who have cooperated so well in implementation of FMA's legislative programs.

Upon recommendation of the Reference Committee the Supplemental Report of the Committee on State Legislation was adopted as amended with the exception of Item No. 6 which was deferred.

Supplemental Report Committee on State Legislation

SANFORD A. MULLEN, M.D., *Chairman*

This is to update the report of the Council on Legislation and Public Agencies printed in the Delegates' Handbook. This report reflects the status of legislation as of May 1, 1974.

LEGISLATIVE STATUS OF FMA's 1974 LEGISLATIVE PROGRAM

1. **Opposition to Legislation Which Would Require All Insurance Companies to Cover Chiropractic Services in All Policies Written in the State of Florida (CSHB 2929).**
   CSHB 2929 was passed by the House of Representatives and amended by the Senate Commerce Committee. The amendment by the Commerce Committee allows an insured to have chiropractic benefits added to his policy by requesting it from the insurance company. The FMA is trying to retain this amendment on the Senate floor as total defeat of the bill appears unlikely at this time.
2. **Opposition to Establishment of a School of Osteopathy in Florida (SB 883, HB 2847, HB 3729).**
   No hearings have been held on these bills as of this date.
3. **Opposition to Appointment of a Layman to the SBME (SB 94, HB 2275).**
   The Senate bill (SB 94) is still pending in committee and the House bill (HB 2275) was killed in committee.
4. **Opposition to Legislation Requiring Full Disclosure of Ownership in and Transactions With Hospitals, Labs, Optical Shops, and Other Health Facilities by Physicians (SB 464, HB 3854).**
   The Senate bill is in Ways and Means Committee and the House bill has not been considered by Committee as of this date.
5. **Support for Improving Medicaid Benefits for Physicians Services.**
   As of this date, it appears that physician reimbursement will be funded at the level now paid for vocational rehabilitation (75% of 75th percentile) and increases will be approved for drugs and outpatient services. Funding for peer review through the Florida Medical Foundation is also being included.
6. **Support for Legislation to Require Reporting to the Insurance Department of all Completed Malpractice Claims (SB 468, HB 3136).**
   The Senate bill has passed the Senate and the House bill is on the House calendar.
7. **Support Amendment to Bill Making Hospital and Nursing Home Records Available to Patient or his Attorney (HB 1106) Which Would Prohibit Release if Physician Certifies Such Would be Detrimental to Patient's Health.**
   This bill passed the House and is now in Senate HRS Committee without the amendment being sought by the FMA.
8. **Opposition to Establishment of School of Optometry in Florida (SB 364, HB 3107).**
   This bill is in the Ways and Means Committee in the Senate and the Appropriations Committee in the House.
9. **Opposition to Licensure of Nurse Practitioners (HB 2416).**
   This bill is on the House Calendar.
10. **Opposition to Repeal of Anti-Substitution Drug Laws (HB 2802, SB 686).**
    These bills are on the calendar in the House and Senate. Amendments were placed on them to allow substitution only if authorized by the physician and a requirement that the physician be notified of the drug substituted.
11. **Support of Funding for Comprehensive Health Education Program.**
    Inclusion of funds for this program is anticipated in the General Appropriations Act.
12. **Support of Legislation Exempting Physicians from Jury Duty (SB 240, CSHB 170, HB 2864).**
    The Senate bill allows the judge's discretion to exempt a physician and is on the House calendar. The outright exemption bill (CSHB 170, etc.) is on the House Calendar.
13. **Support of Increased Funding for Family Practice Residencies (HB 3363).**
    This bill is now in Appropriations and appears to have good chance of passing.
14. **Support of Legislation Prohibiting Optometrists from Using Drugs and Surgery (SB 838, HB 3791).**
    As of this date, no hearings have been scheduled on these bills.
15. **Support of Statewide Fluoridation Program (HB 1492).**
    This bill is on the House calendar.
16. **Support of Legislation to Require Chiropractic Practitioners to be Graduates of Colleges and Universities Accredited by an Agency Recognized by the Office of Education and the National Commission on Accrediting (SB 847, HB 3779).**
    Both bills are still in committee and have not been scheduled for hearings.

OTHER LATE DEVELOPING LEGISLATIVE ACTIVITIES

The Committee would ask for permission to introduce at the Reference Committee any item of major significance that might have arisen in the Legislature between May 1 and the time of the FMA meeting.

Council on Medical Services
Recommendation 7

The Reference Committee recommended amendment of the first "RESOLVED" of Recommendation No. 7 of the Council on Medical Services Report.

As recommended by the Reference Committee, the first RESOLVED of Recommendation No. 7 of the Report of the Council on Medical Services was amended to read:

"Be It Resolved, Since Plasmapheresis has been defined by the Florida State Board of Medical Examiners as the practice of medicine, that Legislation be enacted to provide for mandatory presence of a knowledgeable, Florida licensed Doctor of Medicine on the premises of each Plasmapheresis center during its hours of operation, and"

(See Report of Council on Medical Services, page 525)

Recommendation 7

Upon recommendation of the Reference Committee, the paragraphs beginning with the words, "WHEREAS," in Recommendation No. 7 of the Report of the Council on Medical Services, were deleted from the report.

Recommendation No. 15

Upon recommendation of the Reference Committee, Recommendation No. 15 was amended by adding the words, "so long as there is concurrence in these actions by the local county medical society." immediately following the words, "provide certain types of health care."

(See Report of Council on Medical Services, page 525)

Recommendation No. 16

Upon recommendation of the Reference Committee, Recommendation 16 of the Report of the Council on Medical Services was adopted.

(See Report of Council on Medical Services, page 525)

Recommendation No. 17

Upon recommendation of the Reference Committee, Recommendation No. 17 of the Report of the Council on Medical Services was amended by adding the words, "and all similar bills which would place the practice of medicine in the category of a Public Utility," between the words, "1974" and "be vigorously."

(See Report of Council on Medical Services, page 525)

Report of Board of Governors

Upon recommendation of the Reference Committee, the section of the Board of Governors Report entitled, Florida Statewide Medical Examiners System, was filed for information.

Upon recommendation of the Reference Committee, the section of the Board of Governors Report entitled, Resolution No. 73-13 "State Allocations for Control of Drug Abuse," was filed for information.

Recommendation No. 8
Death with Dignity

The Reference Committee recommended that Recommendation No. 8 of the Board of Governors Report concerning Death with Dignity be adopted.

A substitute motion was made from the floor to refer the matter of Death with Dignity to the Board of Governors for continuing observation and consideration. The substitute motion was seconded and discussed.

The motion carried.

New FMA President Thad Moseley, M.D., Jacksonville, and Mrs. Moseley.

Upon recommendation of the Reference Committee, the section of the Report of the Board of Governors pertaining to Milk Inspection was adopted.

The Reference Committee recommended that the Board of Governors continue to oppose this type of legislation.

The recommendation was adopted.

Upon recommendation of the Reference Committee, the section of the Report of the Board of Governors pertaining to "Active Opposition" was filed for information.

AD HOC Committee on
Governmental Reorganization

Upon recommendation of the Reference Committee, the report of the Ad Hoc Committee on Governmental Reorganization was filed for information.

Supplemental Report
Committee on State Legislation
Item 6 Resolution 74-7
Professional Liability Insurance Claims Reports
Polk County Medical Association
Resolution 74-23
Professional Liability Limit
Emmet F. Ferguson Jr., M.D., Delegate
Resolution 74-24
Professional Liability Lawsuits
Duval County Medical Society
Resolution 74-28
Professional Liability Lawsuits
Palm Beach County Medical Society
Resolution 74-31
Central Reporting of Malpractice Claims
Dade County Medical Association
Resolution 74-35
Malpractice Insurance
Ray E. Murphy Jr., M.D., Delegate

The Reference Committee indicated that these recommendations and resolutions were considered together because they all pertain to legislative relief for the problem of professional liability insurance, and recommended adoption of a substitute resolution to be called Substitute Resolution 74-7.

A motion was made from the floor to amend the Substitute Resolution by striking the words which appear in section 1, "by the insurance carrier to the State Board of Medical Examiners" and inserting the words, "to the Department of Insurance."

The amendment to the substitute motion carried.

As recommended by the Reference Committee and amended by the House, Substitute Resolution 74-7, Professional Liability Insurance Claims Reports, was adopted.

Substitute Resolution 74-7

Professional Liability Insurance Claims Reports

RESOLVED, That the Florida Medical Association legislative activities include, but not be limited to:

1. Endorsement of SB 468 and HB 3136, passed in the Senate and now on the House calendar, which provide for reporting to the Department of Insurance or State Board of Osteopathic Medical Examiners of professional liability claims or action for damages along with appropriate statistical information.
2. Legislation to require the posting of a bond by the plaintiff to indemnify the defendant physician in those cases that end in a verdict for the defendant, and to work with other similarly affected professional groups to accomplish this purpose.
3. Legislation to establish a dollar limit of liability for any medical liability responsibility, and provision for a patient to purchase insurance coverage above this limit of liability.

Resolution 74-16
Ear Piercing
Volusia County Medical Society

Upon recommendation of the Reference Committee, Resolution 74-16—Ear Piercing, was adopted.

Resolution 74-16

Ear Piercing

RESOLVED, That the Florida Medical Association urge the Florida State Legislature to enact proper legislation to protect the public from viral hepatitis transmitted by ear piercing.

Resolution 74-17
Mandatory Continuing Education for Licensure
Broward County Medical Association

Upon recommendation of the Reference Committee, Resolution 74-17, Mandatory Continuing Education for Licensure, was adopted.

Resolution 74-17

Mandatory Continuing Education for Licensure

RESOLVED, That the physicians of Florida instruct its members and officers to oppose any legislation which would mandate graduate education requirements as a requisite to continuing license renewal.

Dr. Rush: "Your Chairman wishes to thank the members of this Reference Committee, Doctors Robert P. Johnson, Karl R. Rolls, Dick L. Van Eldik, and Charles A. Monnin, Jr., and the members who came to speak before the committee. Without the efforts, assistance, and cooperation of all the above, this report would not have been possible. This Reference Committee especially wishes to thank Mary Kay Samorisky, our Secretary, for her assistance in the preparation of this report."

"Mr. Speaker, I move the adoption of the Report of Reference Committee No. IV as a whole as amended."

Reference Committee No. IV was adopted as amended.

"Mr. Speaker, this concludes the report of Reference Committee No. IV."

Report of Reference Committee No. V

Medical Economics

The Vice Speaker assumed the Chair and called for the report of Reference Committee No. V, Medical Economics.

Dr. John C. Fletcher, Chairman, and members of the Reference Committee came forward to present the report of Reference Committee No. V.

Council on Medical Economics

Upon recommendation of the Reference Committee, the Report of Council on Medical Economics was published and filed.

Council on Medical Economics

IRVING M. ESSRIG, M.D., *Chairman*

The Council on Medical Economics held two meetings this year, September 23, 1973, and March 3, 1974. During this time the Council considered recommendations of its Committees, namely: Advisory to Blue Shield and Fiscal Intermediaries (Committee of 17), Chairman, Raymond J. Fitzpatrick, Gainesville; Health Insurance, Chairman, Curtis W. Cannon, West Palm Beach; Hospitals and Extended Care Facilities, Chairman, J. Russell Forlaw, Boynton Beach; Peer Medical Utilization Review, Chairman, James B. Byrne, Miami; Relative Value Studies, Chairman, Fred A. Butler, Naples; Computerization in Medicine, Chairman, Richard D. Hoover, West Palm Beach. Most of these recommendations were endorsed by the Council while a few were disapproved.

It also directed its attention to matters referred by the Board of Governors, Council on Specialty Medicine, and Judicial Council, as well as spending much time and thought on subjects brought up by various Council members.

The Council has also recommended that all economic activities of the Florida Medical Association, whether standing or ad hoc, should be funnelled through the Council on Medical Economics.

In an effort to correlate the vast amount of work performed by the Committees of this Council, the Council recommended the establishment of a Master Schedule of Meetings so that committees will meet prior to a Council meeting which should be held prior to Board of Governors meetings so that an efficient flow through the proper channels might occur without undue delay.

The Council was asked to investigate whether sentiment existed for a meeting of Chiefs of Hospital Medical Staffs around the state, but to date has had only one county society requesting such a meeting. It would appear that there is no widespread interest for FMA to conduct a conference for Chiefs of Medical Staffs.

The Board of Governors approved in principle the co-sponsorship of an AMA/ERF Practice Management Workshop for Florida for physicians establishing themselves in private practice and directed the Council to implement the program, if feasible. A limited number of these workshops is conducted by the AMA, and Florida is indeed fortunate to obtain one. The Council is therefore recommending that FMA co-sponsor the Practice Management Workshop in November, 1974, that it be held in Tampa and that a committee with representation from the three medical schools and the Council on Medical Economics be appointed to make the necessary arrangements.

The Council was requested by the Judicial Council to respond to a protest regarding implications of Part "A" Medicare hospital reviews. A letter was sent to the Chairman of the Judicial Council expressing the Council's viewpoint.

The Council further recommended that a committee of experienced, knowledgeable, and conscientious physicians be appointed for a new study to properly relate charges and fees with respect to relativity, to fairness

Reference Committee V was chaired by John C. Fletcher, M.D., Tampa. Others (left to right) are: William W. Thompson, M.D., Fort Walton Beach; Paul C. Harding, M.D., Orlando; John N. Carlson, M.D., Sarasota; Mrs. Jerry Crosby, Recorder; and Marshall Hall, M.D., Miami.

and appropriateness to amplify the findings of the Committee on Relative Value Studies which only reflect current charges and fees.

In response to a request from the Board of Governors concerning Resolution 73-12 regarding the posting of hospital charges, the motion was adopted that the original resolution be reaffirmed and implemented. There is obvious widespread concern about rising hospital costs and the Council strongly endorses the sentiments of Resolution 73-12. There is insufficient staff support and no budget for the Committee on Hospitals and Extended Care Facilities, whose specific duty in the By-Laws is to serve as liaison with the Florida Hospital Association and other health facility organizations, to implement 73-12. Council recommends that the original resolution be acted upon and that the Board of Governors through its staff carry out the wishes of the House in this matter.

The Council was also requested by the Board of Governors to study a request from the Health Insurance Council for medical peer and utilization review. It urges that negotiations be undertaken and notes that the Committee on Health Insurance is specifically charged in the By-Laws with liaison with the Health Insurance Council.

The motion of the Council in September 1973, that there was wide disillusionment with the Usual, Customary and Reasonable concept and that UCR be discontinued and an alternative method established and implemented was initially approved by the Board of Governors in October and then rescinded in January. The Council at its March, 1974, meeting urged the Board of Governors to re-examine Board Resolution 73-10-79 because the Council is convinced that the average physician, purchaser, and consumer does not understand the deficiencies, inequities or obscurities present in the UCR concept. Even the definitions vary and "prevailing" has now been adopted by many insurance carriers which in actuality is a fixed fee schedule fixed by the carrier. Reduction in percentiles and percentages sent down to FMA by regulation from SSA, BHI or HEW is also creating a fixed schedule. Likewise, by negotiations with state government, relative value studies with fixed conversion factors are also resulting in a uniform fee schedule for state programs. It is quite apparent that all of the National Health Insurance proposals will contain similar schedules. It is inconceivable to the Council that the Blues, who are constantly asking for predictability of costs, made such stringent efforts to retain UCR. Many of the chairmen of the committees of this Council did not opt for UCR, whatever influence this may have on the Board. We urge that a frank reappraisal of the entire fee structure be instituted before we are caught up in a mandated Federal or State fee structure.

Council recommended that sufficient physicians be hired by Blue Shield at adequate compensation to provide current and competent claims review. It has been informed that such funds are available through Medicare.

Committee on Florida Medical Insurance Trust—Certain members of the Council were appointed to a Florida Medical Insurance Trust Committee by the Board of Governors and voluminous correspondence has been accumulated. The duties, functions and responsibilities of this committee are obscure to the new members and, prior to undertaking any action, they have requested a thorough briefing by a Trustee of the Trust.

Committee on Advisory to Blue Shield and Fiscal Intermediaries (Committee of 17)—The committee met four times during the year on May 11, 1973, in Miami, September 9, 1973, in Orlando, December 9, 1973, in Tampa and February 23, 1974, in Jacksonville. The committee continues to function with staff assistance provided by Blue Shield coordinating with the FMA staff.

The chairman and FMA staff for the committee, accompanied by various members of the committee, attended all Blue Shield Board of Directors meetings. The committee has been responsible for Blue Shield's developing a new major medical claim form with a preprinted assignment block. Blue Shield also has initiated printing major medical information on the I.D. cards.

Other activities of the committee were devoted to recommending reinstitution of a newsletter, implementation of which was more difficult than anticipated; recommending that Blue Shield present a UCR profile presentation at its annual meeting this year; recommending that any additional charge for a technical component generated by a free-standing surgical center or other outpatient surgical facility be paid by Blue Cross rather than Blue Shield; recommended that officers of county medical societies of nearby locations be invited to attend the committee meetings as non-voting guests; (recommending that a time limit of 90 days from the date of payment be the time limit for requesting refunds from a physician for Blue Shield private business when an error in payment is made by Blue Shield claims department and is not a result of physician error in claim filing;) (recommending that Blue Shield pay non-participating MDs directly when basic claims are submitted with a signed assignment of benefits from the patient and expressed dismay that this policy was changed in 1972 without consultation with the committee or communication to Florida physicians;) recommending that the FMA, in cooperation with the Florida Hospital Association, institute a review of the procedures for obtaining confidential hospital records.

Committee on Peer Medical Utilization Review—The committee met four times this year for a total of 573 physician hours; the meetings were held on May 6-8, 1973, July 13-15, 1973, September 7-8, 1973 and February 22-23, 1974. The committee reviewed in depth 46 cases, of which 27 were appeals. This is a marked decrease from the 210 cases of last year. Since 1969, the committee has had referred to it a total of 412 physicians. This year, the emphasis has changed from the hospital to the out-patient setting.

The committee found itself with a reduced work load since its last report, due primarily to two factors. Medicare is now requesting complete records from the physicians who, on preliminary review, are found to have exceeded the norm. As a result of this, less than half of the cases previously referred to the Foundation now need review by the committee. Secondly PSRO appears to be the pre-occupation of most of the county medical societies. The type of utilization review which this committee has actively involved itself with since 1969 will become a part of the PSRO functions, but must be continued until its assimilation by the local PSRO.

Among other actions taken by the PMUR Committee, they have recommended that Blue Shield should be advised that the committee does not consider reasonable the fee of $35.00 per hour and wishes to put on record that Blue Shield be informed that future contracts should be based on a minimum of $50.00 per hour for professional time.

After considerable discussion by the committee, a motion was carried unanimously that the committee would not consider providing Peer Medical Utilization Review for Medicaid, either prospective or retrospective, until more details were provided.

The committee wishes to express its gratitude to each and every county peer review committee and to each physician involved. They recognize that peer review is not a pleasant task within each county society but it does remain a necessary chore. Each member of this committee should be commended for his dedication and conscientious efforts. They have served the committee and the Association to the fullest and deserve far more than a simple thank you.

Committee on Relative Value Studies—The committee met three times during the year on June 9, 1973, in Tampa, November 3, 1973, in Orlando and April 6, 1974 in Tampa.

Committee meetings, as in 1973, have dealt largely with all requested changes or additions to the 1971 Relative Value Studies Manual. Several requests have been of sufficient import to justify surveys of one type or another. For example, one survey resulted in an increase in relative value for total obstetrical care.

Repeated complaints, particularly by physicians working with insurance claims, that relative values for plastic surgery are excessive and/or abused has led the Committee to investigate the attitudes of plastic surgeons toward cosmetic surgery, skin repair and various other procedures. After considerable study the Committee feels that while the 1971 Relative Value Studies Manual reflects the fee structure of plastic surgeons in Florida since and before 1970 there are some wide areas of disagreement as to allowable fees between physicians in this field and insurance companies and their medical review committees. While the RVS Committee is not a fee schedule committee, this matter has caused such concern that the Committee has asked the Board of Governors to authorize an in depth study and revision of this section of the Manual which will achieve the most practical, realistic and fair treatment of these procedures possible.

There have been a large number of changes in procedures and code numbers in the Third Edition of Current Procedural Terminology as compared to the Second Edition, on which most of the 1971 Manual was based. This has resulted in about 18% of the procedures in the 1971 Manual not conforming with the CPT Third Edition. Although many of these changes are minor, some are important and involve high frequency procedures and reflect changes in medical and surgical techniques as well as new and obsolete procedures. The Committee has recommended a limited revision to bring the Manual in line with the CPT Third Edition and this is under consideration by the Board of Governors at the present.

Despite the failure of Medicare to adopt or encourage use of CPT nationally and the continuing use of older nomenclature by Blue Shield in settling claims, the 1971 Manual has achieved widespread acceptance in Florida. During 1973 all State of Florida programs paying fees to private physicians adopted the Manual with a uniform conversion factor for compensation. The Veterans Administration has similarly adopted the Manual in Florida. On the basis of favorable letters received and the continued demand for Manuals, physicians and insurance companies are using the Manual as a guide in increasing numbers. As of now the initial printing of 12,000 Manuals has been almost exhausted, and a reprinting is scheduled.

Committee on Health Insurance—The committee met three times during the year on July 14, 1973, November 10, 1973, and March 2, 1974. The operating procedures adopted by the Board of Governors last year have provided the committee with a solid base. The committee has found only minor problems in these procedures and has requested changes through channels.

The committee, this past year, received 113 requests for assistance, primarily from insurance companies. These were forwarded to the respective medical societies for local review. Forty-two appeals were heard and at this time only one is being held in abeyance.

The cases do not overwhelmingly reflect problems attributable to any one specialty, with the exception of plastic surgery. The problems of determining cosmetic versus reconstructive surgery and plastic versus non-plastic closure remain and continue to provide the bulk of the committee's activities.

A tentative meeting of the committee is planned prior to the Annual Meeting in May, provided a sufficient number of cases are received to review. Each member of the committee is to be commended for his tireless dedication and efforts for the successful conclusion of each case reviewed.

This committee would like to encourage each County Medical Society committee to more fully utilize the 1971 Relative Value Studies in their deliberations, realizing the need to adopt flexible and realistic conversion factors.

Committee on Hospitals and Extended Care Facilities—The committee held three meetings during the past year. These were on August 5, 1973, in Miami, September 21-22, 1973, in Miami, and March 2, 1974 in Miami.

The committee spent many hours in revising the Model Medical Staff By-Laws of the Florida Medical Association. These new guidelines for Medical Staff By-Laws should be available in the near future.

The committee has also investigated several problems involving hospitals brought to its attention by various members of the Association.

The committee reaffirmed the FMA position that hospital medical staffs have representation on the Governing Bodies of hospitals.

The committee also recommended that hospital utilization review committees be paid for time spent in review.

Committee on Computerization in Medicine—The committee held no formal meetings during the past year but continues to function on an informal basis under the direction of the chairman.

The committee is in the process of evaluating responses to a questionnaire sent to Florida physicians in order to determine to what extent physicians are using computers and to also give the committee some guidance in relation to the direction its activities should take.

The committee also plans to invite several computer firms to exhibit at the Annual Meeting.

Report of Board of Governors

Referrals by 1973 House of Delegates Resolution 73-2

Professional Fees in a Teaching Hospital

Upon recommendation of the Reference Committee, Resolution 73-2, Professional Fees in a Teaching Hospital, was not adopted.

Mrs. William H. Mathews, Jacksonville, outgoing President of the Woman's Auxiliary, renders her report in song. The score was from "Sound of Music" but the lyrics were Mrs. Mathews' own.

Resolution 73-18
Blue Shield Master Medical Coverage

Upon recommendation of the Reference Committee, Resolution 73-18, Blue Shield Master Medical Coverage, was referred back to the Board of Governors for continued review.

Board Action No. 5
Professional Standards Review Organization (PSRO)

Upon recommendation of the Reference Committee, Board Action No. 5, Professional Standards Review Organizations, was filed.

Board Action No. 9
Florida Medical Insurance Trust

Upon recommendation of the Reference Committee, Board action No. 9 was adopted.

(See Report of the Board of Governors, page 533)

Board Action No. 10
PMUR Contract

Upon recommendation of the Reference Committee, Board action No. 10 was adopted.

(See Report of the Board of Governors, page 533)

Board Action No. 11
Conference with Chiefs of Medical Staffs

In view of the Council on Medical Economics' comments on this issue, the Reference Committee recommended that Board Action No. 11 be filed.

Board Action No. 11 was filed.

Board Action No. 19
HRS Fee Schedule

The Reference Committee recommended that Board Action No. 19 be amended by deleting the word, "maximum" in the last sentence of the first paragraph and deleting the last part of the action beginning with the words, "The maximum schedule should be . . ."

Board Action No. 19 was amended as recommended by the Reference Committee and adopted as amended.

(See Report of the Board of Governors, page 534)

Board Action No. 24
Provider-Based Physicians Workgroup

Upon recommendation of the Reference Committee, Board Action No. 24, Provider-Based Physicians Workgroup, was adopted.

(See Report of the Board of Governors, page 535)

Board Action No. 29
Blue Shield—Chiropractic Claims

Upon recommendation of the Reference Committee, Board Action No. 29, Blue Shield—Chiropractic Claims, was adopted.

(See Report of the Board of Governors, page 535)

Board Action No. 30
Florida Society of Ophthalmology

Upon recommendation of the Reference Committee, Board Action No. 30, Florida Society of Ophthalmology, was adopted.

(See Report of the Board of Governors, page 535)

Reports of Councils
Medical Economics

Upon recommendation of the Reference Committee, items under the Medical Economics section of the Report of the Board of Governors that were referred to R.C. V were adopted.

(See Report of the Board of Governors, page 541)

Subcommittee on Foundations for Medical Care

The Reference Committee recommended that this report be referred back to the Board of Governors for further action, noting that this area of involvement would require FMA approval and guidance to properly monitor the progress of a pilot project for the Duval County Foundation for Medical care and that this project will establish a Foundation type open-ended, prepaid plan for medical care and possibly serve as a model for other areas in the State trying to undertake this type of program.

The Report of the Subcommittee on Foundations for Medical Care was referred back to the Board of Governors for further action.

Subcommittee on Foundations for Medical Care

James L. Borland Jr., M.D., *Chairman*

[Not Adopted—Referred to Board of Governors]

The committee held its first meeting on January 25, 1974. This meeting provided an interesting insight into the local foundations' involvement within their community. Some are heavily committed, others exist in name only.

Some of the areas of involvement are:

1. PSRO
2. EMCRO
3. Pre-School Exams
4. Head Start Health Maintenance
5. Pre-payment Program

With the passage of the National HMO Bill, the Legislature is beginning to consider various ways to capitalize and as a result local bills are coming into being. The committee is being requested to act as the sounding board for these bills.

The committee commends each foundation for their involvement and encourages those not now operational to become so. There are community needs which can be filled by physicians working within their own framework.

Resolution 74-4
Federal Programs—Pre-Certification
Pinellas County Medical Society

Upon recommendation of the Reference Committee, Resolution 74-4, Federal Programs—Pre-Certification, was adopted.

Resolution 74-4

Federal Programs—Pre-Certification

RESOLVED, That 20 CFR, Part 405, as published in the Federal Register, Vol. 39, No. 6—January 9, 1974, the pre-certification of elective admissions or post-certification of ordinary and emergency admissions, is a totally unacceptable concept to the practicing physicians of Florida, ideologically and economically in cost to the patient and the government; and in the interest of quality medical care for our patients we will not participate.

Resolution 74-8
Professional Standards Review Organizations
Orange County Medical Society

Resolution 74-9
Florida Professional Standards Review Organization
Lee County Medical Society

Resolution 74-10
Professional Standards Review Organization
Manatee County Medical Society

Resolution 74-11
Non-Participation in PSRO Program
Volusia County Medical Society

Resolution 74-19
PSRO Implementation
DeSoto-Hardee-Glades County Medical Society

Resolution 74-20
PSRO Alternative
Everett Shocket, M.D., Delegate

The Reference Committee indicated that these resolutions were considered together because they dealt with the same subject. The Committee indicated that it was privileged to hear Dr. Von Thron's Presidential Address and listened carefully to testimony on P.L. 92-603 (PSRO), Section 249F, and its initial regulations promulgated by the Department of HEW. Testimony in favor of continued effective Peer Medical Review was virtually unanimous and recognition was given to the fact that the FMA already has an effective Peer Review organization. It was the feeling of the Reference Committee that this organization should be charged with the responsibility of providing broader coverage for other facets of medical care and recognized that P.L. 92-603 (PSRO) will not provide effective Peer Review and will destroy the unique system which has been developed in Florida over the past five years through hard work by many dedicated physicians. In view of this, the Reference Committee recommended adoption of Substitute Resolution 74-8, Professional Standards Review Organizations, in lieu of Resolutions 74-8, 74-9, 74-10, 74-11, 74-19, and 74-20, with the additional recommendation that each "RESOLVED" be voted on individually before going to the next.

Upon recommendation of the Reference Committee, each "RESOLVED" was taken up individually.

The first RESOLVED of Substitute Resolution 74-8 passed.

A motion was made from the floor to delete the second RESOLVED from the Substitute Resolution 74-8. This motion was ruled out of order.

A motion was made from the floor to amend the second RESOLVED by adding after the words, "outlined in P.L. 92-603," the words, "and the FMA or its Foundations shall not participate in the establishment of any PSRO." The motion was seconded and there was discussion.

A motion to limit debate on the amendment to six minutes passed.

A vote was taken on the amendment but a standing division of the House was called.

A division of the House indicated defeat of the amendment to the second RESOLVED of Substitute Resolution 74-8, by a vote of 90 for the amendment and 108 against the amendment.

A division of the House was called on the vote of the second RESOLVED of Substitute Resolution 74-8. A vote of 109 for the substitute and 95 against the substitute indicated adoption of the second RESOLVED of Substitute Resolution 74-8.

A motion was made from the floor to have a roll call of the House. The motion was seconded but did not pass.

The Credentials Committee was called upon to give an updated count of the seated delegates and a motion to poll the county delegations was defeated.

There was discussion regarding the third RESOLVED of Substitute Resolution 74-8 and a vote was taken. A division of the House was called for and resulted in a vote of 106 for and 90 against the third RESOLVED.

The third RESOLVED of Substitute Resolution 74-8 was adopted.

The fourth RESOLVED of the substitute resolution was adopted.

A motion was made from the floor to amend the fifth RESOLVED by adding the words, "and not under control of any Federal organizations." immediately following, "in many sections of the country."

A vote was taken, but a division of the House was necessary. The amendment passed.

A motion was made from the floor to strike the word "legislative" from the fifth RESOLVED of Substitute Resolution 74-8.

The motion to amend was defeated.

The fifth RESOLVED of Substitute Resolution 74-8 as amended was adopted.

Dr. Moseley, the President, spoke in clarification of the resolution before the final vote was taken.

The motion was made to continue with the injunction that has already been filed in the Federal courts which pertains to the designation of Florida as one PSRO geographical area.

The motion was defeated.

The motion was made that for a period of one year the Board of Governors (a) seek no amendment; (b) seek no injunctions against any new regulations; (c) seek no statewide PSRO support system.

The motion carried.

Upon recommendation of the Reference Committee, Substitute Resolution 74-8, Professional Standards Review Organizations, was adopted as amended.

Substitute Resolution 74-8

Professional Standards Review Organizations

RESOLVED, That the FMA reaffirm its support of Peer Medical Utilization Review as an effective means of promoting and assuring quality medical care, realizing that innovations, improvements, and expansion of coverage will be necessary, and be it further

RESOLVED, That FMA unequivocally and emphatically reject the PSRO substitute for Peer Review as outlined in P.L. 92-603, and be it further

RESOLVED, That the Florida Medical Association encourage its membership to exercise their option not to participate in PSRO (P.L. 92-603), and be it further

RESOLVED, That the Florida Medical Association members individually and collectively promote the repeal of Sect. 249F, P. L. 92-603, and be it further

RESOLVED, That future legislative efforts should be made to develop a system more closely approaching Peer Medical Utilization Review now operational in many sections of the country and not under control of any Federal organizations.

President Joseph C. Von Thron, M.D., presents FMA's Certificate of Appreciation to William M. C. Wilhoit, M.D., Pensacola, as Mrs. Wilhoit looks on.

Resolution 74-12
Workmen's Compensation
Sarasota County Medical Society

The Reference Committee recommended that Resolution 74-12 be amended by adding the words, "Florida Medical Association petition" between "RESOLVED, That" and "the Workmen's" and to delete the words, "Medical Section." The Reference Committee also recommended that "as updated" be added to the end.

The Resolution was adopted as amended.

Resolution 74-12

Workmen's Compensation

RESOLVED, That the Florida Medical Association petition the Workmen's Compensation Division to immediately implement the entire 1971 Florida Relative Value Studies as updated.

Resolution 74-18
Statewide PSRO Support Center
Broward County Medical Association

The House was advised by the Reference Committee that since Resolution 74-18 had no sponsor present at the Committee meeting, it was not considered. This was in accordance with the Rules of Order.

Resolution 74-13
Hospital Admission Screening Tests
Everett Shocket, M.D. Delegate

Upon recommendation of the Reference Committee, Resolution 74-13 was adopted as amended by the Reference Committee.

Resolution 74-13

Hospital Admission Screening Tests

RESOLVED, That the FMA recommend that all *routine* admission screening tests or procedures be carefully studied by the local medical staff to insure that duplication and unnecessary tests are not performed.

Resolution 74-15
Blue Shield
Orange County Medical Society

Upon recommendation of the Reference Committee, Resolution 74-15 was adopted.

Resolution 74-15

Blue Shield

RESOLVED, That the House of Delegates of the Florida Medical Association continues its pledge of support and expresses its confidence in the Board of Directors and Executive Staff of Blue Shield of Florida.

Resolution 74-21
Payment of Benefits
Palm Beach County Medical Society

The Reference Committee considered Resolution 74-21 and heard testimony relating to a typographical error in line 15, and corrected this with substitution of the word, "assignment" in lieu of the word, "payment."

Upon recommendation of the Reference Committee, Resolution 74-21 was not adopted.

Resolution 74-26
Physicians' Fees
FMA Executive Committee

Upon recommendation of the Reference Committee, Resolution 74-26 was adopted.

Resolution 74-26

Physicians' Fees

RESOLVED, That the House of Delegates of the Florida Medical Association endorse wholeheartedly the appeal of the Chairman of the Board of Trustees of the American Medical Association for voluntary restraint on fee increases, and be it further

RESOLVED, That the House of Delegates urges all FMA members contemplating fee increases to assure that such adjustments do not exceed parity with increases in the cost of living as reported by the Bureau of Labor Statistics, U.S. Department of Labor.

Resolution 74-27
Hospital Reviews
Everett Shocket, M.D., Delegate

The Reference Committee considered Resolution 74-27. Testimony and Committee study indicated the uniqueness of this experience, noting that this review was not in keeping with the usual FMA Peer Medical Utilization Review philosophy. This departure from usual procedures was dictated by a prior binding agreement by the hospital authority and the Federal Government. The FMA reviewing body served only as a consultant to the issue. The Reference Committee learned that appeal mechanisms were available to the concerned attending physicians but were not utilized.

Upon recommendation of the Reference Committee, Resolution 74-27 was not adopted.

Resolution 74-32
Updating of 1971 Relative Value Studies
Dade County Medical Association

The Reference Committee heard testimony which indicated that there seems to be a problem of relativity of charges and relativity of services. The report of the Council on Medical Economics reports current plans for updating and revision of this manual and a request to the Board of Governors to authorize this project. The Reference Committee felt that the RVS Committee should be expanded to include expert consultants to resolve possible inequities in relativity of bill charges and relativity of services performed.

Upon recommendation of the Reference Committee, Resolution 74-32 was adopted.

Resolution 74-32

Updating of 1971 Relative Value Studies

RESOLVED, That this House of Delegates instruct the Board of Governors to have the 1971 Florida Relative Value Schedule updated to accurately reflect the relative value of medical services listed in all sections of the manual.

Resolution 74-34
Florida Medical Insurance Trust
Dade County Medical Association

Upon recommendation of the Reference Committee, Resolution 74-34 was adopted.

Resolution 74-34

Florida Medical Insurance Trust

RESOLVED, That the Florida Medical Insurance Trust Committee meet with the Council of Florida District Branches of the American Psychiatric Association (representing psychiatry in Florida) without delay for the purpose of restoring major medical coverage of nervous and mental disorders in the Florida Medical Insurance Trust.

Dr. Fletcher: "Your Chairman wishes to thank the members of this committee, Doctors William W. Thompson, John N. Carlson, Paul C. Harding, and Marshall Hall, and the members who came to speak before the committee and our secretary, Jerry Crosby, without whose efforts, cooperation and assistance this report would not have been possible."

"Mr. Speaker, I move the adoption of the Report of Reference Committee No. V as a whole as amended."

The Report of Reference Committee No. V was adopted as amended.

"Mr. Speaker, this concludes the report of Reference Committee No. V."

The motion was made from the floor to reconsider the vote by which the President's Address was filed for information, as appeared in the Report of Reference Committee No. III. This motion was seconded and a standing vote was required.

The motion failed with a vote of 73 for reconsideration and 80 against reconsideration of the motion to file.

The Vice Speaker turned the Chair over to Dr. Burns A. Dobbins for presentation of a special resolution.

Dr. Dobbins presented to the House of Delegates, for their information, the following Resolution which will be submitted to the AMA House of Delegates in Chicago in June:

Resolution Commendation of W. Harold Parham, D.H.A.

Florida Delegation

Whereas, during the Centennial meeting of the Florida Medical Association May 11, 1974, its Executive Vice President, W. Harold Parham was signally honored by the University of Florida and the Degree of Doctor of Health Administration was conferred upon him by the University with the Deans of all three of Florida's Medical Schools participating, and

Whereas, not only was this the first time this degree has been conferred, but it was the first time that the University of Florida has offered any degree away from a regularly scheduled convocation, therefore be it

RESOLVED, That the American Medical Association congratulate and commend Dr. Parham, and be it further

RESOLVED, That the American Medical Association thank him and all of the many dedicated staff personnel who contribute so much to the health care of the American people.

Elections

President-Elect

The Vice Speaker opened the floor for nominations for the office of President-Elect of the Association for 1974-1975.

Dr. Richard M. Dever, Dade County, placed in nomination the name of Dr. Franklin J. Evans of Coral Gables, Florida.

Dr. Evans' nomination was seconded by Dr. Donald G. Nikolaus, Pinellas County; Dr. Henry L. Harrell, Marion County; Dr. Norman F. Coulter, Orange County; Dr. Carlos G. Llanes, Dade County; and Dr. William B. King, Broward County.

Dr. James R. Forlaw of Palm Beach County placed in nomination the name of Dr. Vernon B. Astler of Boynton Beach.

Dr. Astler's nomination was seconded by Dr. Gerold L. Schiebler, Alachua County; Dr. David T. Overbey, Pinellas County; Dr. Clarence M. Gilbert, Orange County; Dr. David C. Lane, Broward County; Dr. Robert E. Willner, Dade County; and Dr. George S. Palmer, Capital County.

Nominations were closed and upon secret written ballot Dr. Astler was elected and requested to come to the podium.

Dr. Curtis Cannon and Dr. James R. Forlaw escorted Dr. Astler to the podium.

Vernon B. Astler, M.D., makes a brief expression of gratitude to the House of Delegates soon after the House was informed it had just named him President-Elect of the Association.

Dr. Astler: "I approach this podium with extreme humility because of the prestige of this office and because of the physicians who preceded me in the office. I would like to thank all the delegates who voted for me and supported me, particularly my own delegation and Mr. Mike Lopez, our Executive. I would also like to thank my wife for enduring through this whole ordeal through the last few days and I would like to say that as best that I can, I will try to offer leadership in the tradition of free enterprise medicine."

Vice President

The floor was opened for nominations for the office of Vice President.

Dr. Louis E. Cimino of Hillsborough County, placed in nomination the name of Dr. Irving M. Essrig of Tampa.

Dr. Essrig's nomination was seconded by Dr. Henry J. Babers Jr., Alachua County; Dr. Robert E. Windom, Sarasota County; Dr. John W. Glotfelty, Polk County; Dr. James L. Borland Jr., Duval County; Dr. John M. Young, Escambia County; Dr. James F. Richards, Orange County; Dr. Francis L. Howington, Lee County; and Dr. Maurice H. Laszlo, Dade County.

Dr. Thomas B. Thames, Orange County, placed in nomination the name of Dr. Merrill M. C. Wilhoit of Pensacola.

Dr. Fred A. Butler of Collier County seconded Dr. Wilhoit's nomination.

Nominations were closed and upon secret written ballot Dr. Essrig was elected and requested to come to the podium.

Dr. Essrig was accompanied to the podium by Dr. Richard Hodes and Dr. Donald Nikolaus.

Speaker of the House

The floor was opened for nominations for the office of Speaker of the House.

Dr. Edward W. Stoner of Orange County placed in nomination the name of Dr. Louis C. Murray of Orlando.

Dr. Murray's nomination was seconded by Dr. Leo M. Wachtel Jr. of Duval County; Dr. Francis C. Coleman, Hillsborough County; Dr. William M. Straight, Dade County; Dr. Gerold L. Schiebler, Alachua County.

Nominations were closed and a unanimous ballot cast for Dr. Murray.

Vice Speaker

Nominations for the office of Vice Speaker of the House were called for.

Dr. Richard C. Clay of Dade County placed in nomination the name of Dr. Rufus K. Broadaway of Miami.

Dr. Broadaway's nomination was seconded by Dr. William T. Haeck of Duval County.

Dr. Philip B. Phillips of Escambia County placed in nomination the name of Dr. Charles J. Kahn of Pensacola.

Dr. Kahn's nomination was seconded by Dr. Emmet F. Ferguson Jr. of Duval County, and Dr. Charles K. Donegan of Pinellas County.

The nominations were closed and upon secret written ballot Dr. Charles J. Kahn was elected.

Secretary-Treasurer

Nominations for the office of Secretary-Treasurer were called for.

Dr. Sanford A. Mullen of Duval County placed in nomination the name of Dr. James W. Walker of Jacksonville.

Dr. Walker's nomination was seconded by Dr. Joseph Davis of Dade County; Dr. Thomas E. McKell of Hillsborough County; and Dr. Robert E. Windom of Sarasota County.

Nominations were closed and a unanimous ballot was cast for Dr. Walker.

AMA Delegates

The Speaker called for nominations for election of AMA Delegates and Alternates for two year terms beginning January 1, 1975 and expiring December 31, 1976.

The motion was made from the floor to re-elect the entire slate of delegates by acclamation for the entire two-year term.

The motion was seconded and carried.

The delegates are as follows:

Delegate	Dr. Samuel M. Day	Seat No. 2
Alternate	Dr. Jack Q. Cleveland	
Delegate	Dr. Francis T. Holland	Seat No. 3
Alternate	Dr. Francis C. Coleman	
Delegate	Dr. Richard G. Connar	Seat No. 5
Alternate	Dr. Charles K. Donegan	

The Speaker referred the House to the report of the Board of Governors, in which it nominated James A. Winslow Jr., M.D. of Tampa, for re-election to the Judicial Council for a five-year term to expire in 1979.

Motion carried that Dr. Winslow be re-elected to membership on the Judicial Council.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report, and asked for additional nominations from the floor.

Dr. Hugh L. Boyd of Palm Beach County, placed in nomination the name of Dr. Curtis W. Cannon of West Palm Beach to fill the vacancy occurring in District 11. The nomination was seconded by Dr. Bernard Kimmel of Palm Beach County.

The House was advised that Dr. Charles M. Harris, the Board of Governor's nominee for District 11, had retired and consequently withdrawn from the nomination.

Dr. Cannon was unanimously elected for District 11 and the remainder of the nominees submitted by the Board of Governors were unanimously elected to the Committee on Membership and Discipline. (See report of Board of Governors, page 531).

The Chair was turned over to Dr. Moseley, the new President, who remarked that the officers and Board will do their best to carry out the will of the House.

Dr. Moseley announced that the post convention Board meeting will be held in the Embassy

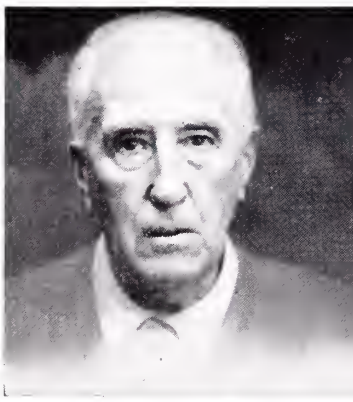
Room immediately following adjournment of the House. He announced that AMA Delegates are invited and that the following Board members have been selected:

Thad Moseley, M.D., Chairman and President
Vernon B. Astler, M.D., President-Elect
Irving M. Essrig, M.D., Vice President
James W. Walker, M.D., Secretary-Treasurer
William J. Dean, M.D., Past President
Joseph C. Von Thron, M.D., Immediate Past President
J. Lee Dockery, M.D., Alternate
Theodore J. Marshall, M.D., Dist. A
Jack A. MaCris, M.D., Dist. B
Thomas B. Thames, M.D., Dist. C
Richard C. Dever, M.D., Dist. D
Francis T. Holland, M.D., AMA Delegate
Advisory Members:
Louis C. Murray, M.D., Speaker of House
Eugene G. Peek Jr., M.D., Dept. of HRS
Joseph G. Matthews, M.D., Blue Shield

Dr. Moseley announced that the following Council Chairmen had been selected:

Vincent P. Corso, M.D., Chairman, Judicial Council
Sanford A. Mullen, M.D., Chairman, Council on Legislation and Regulation
James F. Richards, M.D., Chairman, Council on Medical Economics
Robert E. Windom, M.D., Chairman, Council on Medical Services
Gerold L. Schiebler, M.D., Chairman, Council on Scientific Activities
James L. Borland, M.D., Chairman, Council on Medical Systems
Frederick C. Andrews, M.D., Chairman, Council on Specialty Medicine

The 1974 House of Delegates adjourned at 1:33 p.m.



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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendiu of the type I envision would fill a definite need for the practi ing physician. Such compendium wou give him all th information nec essary for usin a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reaction with other drugs.

The information would be based on the package insert and have the same legal status. In fact a complete compendium with com plete and current information might even eliminate the necessit

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every yea

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indic tions for use, side effects, adverse drug reactions, contraindications drug interactions, drug dosage ar the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing phy sician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor c how to use drugs. Rather, it must be a reference source designed pr marily to refresh his memory as to drugs he may not use regularly. It

a package insert in many in-
nces. This would constitute a
stantial saving for the manu-
:urer.

By a complete compendium,
not mean a volume of prohibi-
size. You don't need a book
cribing 25,000 products with
enormous amount of repetition.
her, drugs should be arranged
class. Mutually applicable infor-
tion would be provided, along
n brief discussions pinpointing
erences in specific drugs of
t class. Listings would be cross-
exed in a useful way.

**ier Available Documents as
irces of Information**

Existing references such as
R and the AMA Drug Evaluation
obviously useful but they are
omplete. Either they are not
ss-referenced by generic name
l do not group drugs with simi-
characteristics, or they do not
all the available and legally
rketed drugs. And some of
se omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

ould in no way imply control over
e practitioner's prerogatives.

ıy Another Compendium?

A practicable, single-volume
mpendium cannot, nor is it
cessary to, include all drugs on
e market today. From my prac-
e of internal medicine for some
years, my experience as a con-
ltant, and as a faculty member
four or five medical schools, I
ould estimate that a doctor uses
ly 30 to 35 drugs regularly. The
972 Physicians' Desk Reference,
cidentally, contained about
500 entries.

As to whether there should be
ederal compendium, in my opin-
n, as stated earlier, the answer is
sy—there should *not* be one. The
oposal assumes that existing
ompendia are inadequate. We're
ot sure of that at all. Whatever its
nperfections, the present drug
formation system in the U.S. is
pen, multifaceted, pluralistic and
tensive. Good compendia exist,
well as other ample sources on
ug therapy, ranging from journal
erature through AMA Drug Evalu-
ion to company materials. Not
l physicians may use such
ources as often or as well as they
ould, but that is the fault of the
an, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

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JULY, 1974 • VOLUME 61 • NUMBER 7

Mandibular Ankylosis Surgical-Orthodontic Treatment

GILBERT B. SNYDER, M.D. AND WILLIAM SILVER, D.D.S.

Abstract: A case history of a 14 year-old boy with severe temporomandibular ankylosis is presented. The dramatic results of ankylosis correction, orthodontia and cosmetic surgery to the nose and chin are discussed and illustrated.

The objective of this article is to illustrate the advantages of a professional "team" approach leading to total habilitation in a patient exhibiting severe facial deformity. There are no innovations; there is only an application of basic principles leading to restoration of a more normal facial appearance.

Case Report

The patient was first seen December 1970 from El Salvador. He was 14 years old but in body size appeared to be only seven or eight. His complaint was inability to open his mouth and self-consciousness regarding his facial appearance (Figs. 1A & B). There were four siblings, all were well without deformity.

He had fallen twice at six months of age striking his chin on both occasions. Since that time the family noted an arrested development of the mandible and total inability to open the mouth.

At age eight the boy had a surgical procedure on the left temporomandibular joint in Mexico with no apparent success. He had not grown in height or weight since that time. He consumed only liquids, but his health remained good in spite of his handicap.

Physical examination disclosed a small statured micrognathic boy who had minimal motion at both temporomandibular joints. His teeth were closed together in Class II occlusion. There was considerable crowding and a bimaxillary protrusion (Figs. 2A & B). He had an associated mandibular ramus asymmetry. A left preauricular incision from the surgery performed in Mexico in 1964 was present. No chin scars were apparent. Roentgenographic examination of the mandible showed a left condyle ankylosis. The skeletal bone age was 10-10½. The Childrens Medical Center, Boston Massachusetts, Anthropometric Chart placed the boy in the third percentile in height and weight. He weighed 55 pounds and was 55 inches tall at age 14. The following laboratory data were abnormal: T4 was 2.4 mcg. (normal 4.0-11.0); plasma cortisol 1.3 mcg. % (normal 5-26); creatinine 0.53 gm/24 hours (normal 1-1.8); alk. phos. 190 (normal 30-70); I-131 six-hour uptake was 8%, 24 hour was 12%—this was considered the lower limits of normal.

The patient was considered to have a hypopituitary problem with adrenal-pituitary axis dysfunction. He was not given thyroid extract during surgery for fear of adrenal crisis while under the stress of surgery.

In June 1971 he underwent his first operative procedure in the United States. He had a tracheostomy performed under local anesthesia then immediately went under general anesthesia. The old scar in the left preauricular area was incised. The left condyle region was heavily scarred. A plastic cap (presumably placed at the time of previous surgery) was removed from the outer aspect of the condyle head. Using the osteotome, rongeur and the Hall air drill with burrs, the condyle was detached from its fibrous and bony attachments to the glenoid fossa over an area of one and one-half inches in the frontal and posterior projection and to a depth of one inch. The condyle head was resected. Blunt dissection was required around the muscular attachments between zygoma and mandible without transection of muscle.

At this stage the mouth could be passively opened two inches so that dental impressions were obtained.

After electrocoagulation in the pterygoid fossa the preauricular hockey-stick incision was temporarily closed. Arch-bars were applied and the mandible wired in a prognathic position. A self-curing acrylic was fabricated, the wound opened and a block of the acrylic was molded between the neck of the condyle and the glenoid fossa so as to fully encapsulate the ascending ramus. The height of the implant was approximately one-half inch. The wound was then closed with 5-0 nylon. A modified pressure dressing was applied.

The pathology report on the bone fragments showed only larger than normal lacunae.

Postoperatively the boy was free of complications. He was maintained on a blenderized diet. His tracheostomy tube was removed on the third day and he was discharged on the fourth day. No facial palsy was evident.

Photos were taken on the 11th day. The correction of the micrognathia was readily apparent. X-rays at this time showed the absence of bony union.

Three weeks after surgery the patient's arch-bars were removed and he was able to chew solid food for the first time in his life!

Hormone therapy was started. He was placed on thyroid extract and Anavar (oxandolone).

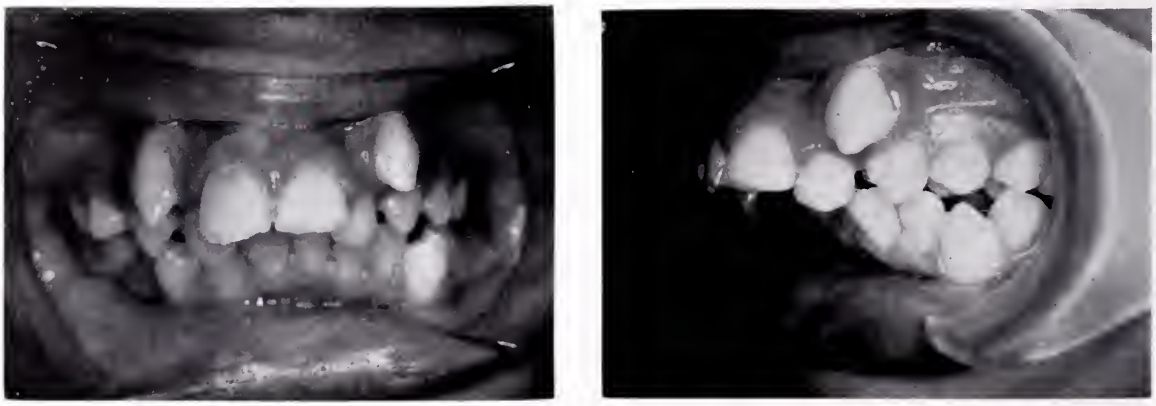
Five months following surgery orthodontic care was instituted. All four permanent first bicuspid teeth were extracted. All four first molars and the upper and lower

Figs. 1A & B. — The patient, age 14, before surgery. He is unable to open his mouth.

six anterior teeth were banded with Begg-type brackets and tubes attached. Therapy began with placement of 0.014 arch-wires to align the teeth and then Class II elastic traction was applied for a period of approximately six months (Fig. 3). Progressive arch-wire changes were made over an eight month period. At this time all maxillary fixed appliances were removed and a Hawley-type retainer placed. The lower fixed appliances were removed without retainer. Final records were taken nine months after orthodontic treatment was instituted (Fig. 4). Cephalometric studies were obtained throughout his growth (Fig. 5).

Fifteen months after surgery plans were made for plastic surgery of the nose and chin. His height at this time was 60½ inches as opposed to 55 inches at the time of the original procedure. All lab data were normal except for continued decreased thyroid activity.

Eighteen months after surgery, a rhinoplasty and augmentation mentoplasty (submental approach) using carved silicone sponge was performed under local anesthesia. Postoperatively the boy had no problems and was discharged the day after surgery. His nasal and chin dressings were removed one week later. Figures 6A and B shows the results three months after surgery.



Figs. 2A & B. — Frontal and left lateral views. He has Class II occlusion with crowding and bimaxillary protrusion.

Fig. 3.—Five months after surgery. Arch-wires (0.014) were used to align the teeth and Class II traction applied. All four first molars, upper and lower six anterior teeth were banded with Begg-type brackets and tubes attached. All four permanent first bicuspid teeth were extracted.

Fig. 4.—Nine months after orthodontic treatment began. These are final records.

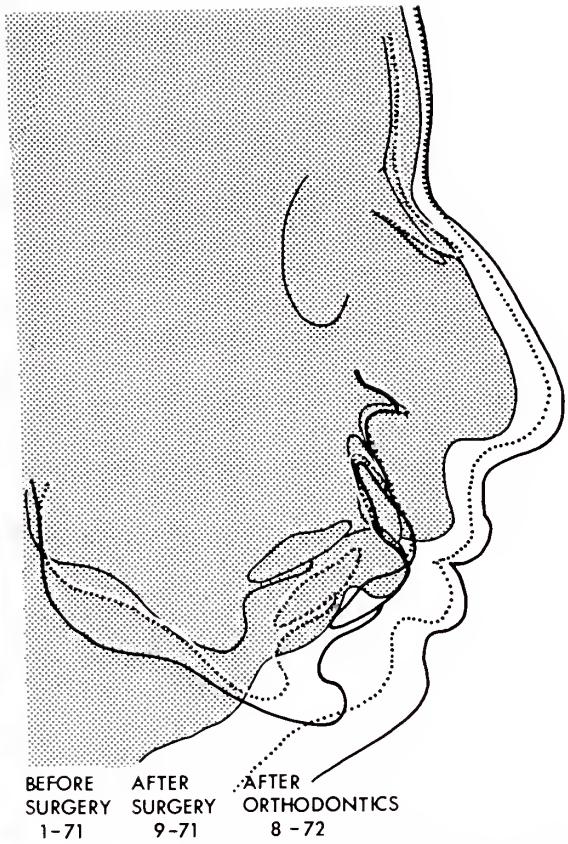


Fig. 5.—Cephalometric analysis of three phases: before surgery (stippled line), after mandible surgery (dotted line) and after orthodontics (solid line). These records were obtained prior to rhinoplasty and chin implant.

Figs. 6A & B. — Three months after rhinoplasty and chin implant. There is still some asymmetry due to deformity of the body of the mandible.

Discussion

The history of facial trauma at an early age may have been the etiology of the arrested growth of the mandible secondary to disturbance of the growth center of the temporomandibular joint (or joints). It is possible that the endocrinopathy further complicated his development.

Why the inability to open his mouth? A bony ankylosis may result from trauma to the chin with disturbance of the temporomandibular joint growth center. This problem was further complicated by unsuccessful surgical intervention at age eight.

There was no restriction of his right temporomandibular joint. Releasing the left side allowed full excursion restricted only by muscle shortening and/or scarring. Had there been other restriction, the same approach was planned on the right temporomandibular joint.

In order to release bony ankylosis of the temporomandibular joint, the full depth of the condylar head must be explored and not just the lateral head (as had been performed previously). This depth is always greater than foreseen and can only be appreciated when, on distracting the mandible downward, the entire glenoid fossa is visualized.

Self-curing acrylic was used for its ease of fabrication and for its nonreactivity. Permanent distraction of the bony parts without resorption or need for bony incorporation was desired; therefore, an autogenous bone block was not appropriate. The plastic material could be inserted while pliable and fitted exactly into the defect without wiring; then allowed to harden conforming to the mandibular ramus and glenoid fossa contour under direct vision.

The release of the bony ankylosis and subsequent orthodontic treatment appeared to allow the normal mandibular growth process to resume. Hormonal therapy may also have played a significant role in this period of accelerated growth and development.

Rhinoplasty and chin augmentation embellished the results of the original surgery. The patient's nose was too large for his facial contour and his chin was still small. This procedure was purely elective and for aesthetic improvement only. Psychologically it was as valid as the first procedure.

Summary

A case report of a facially deformed 14-year-old boy who underwent corrective plastic and oral surgery and orthodontic rehabilitation is presented.

The assistance of Edward Joseph, D.D.S., is gratefully acknowledged.

▶ Dr. Snyder, 1150 Northwest 14th Street, Suite 711, Professional Arts Center, Miami 33136.

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Heat Dyscontrol Syndrome in Patients Receiving Antipsychotic, Antidepressant and Antiparkinson Drug Therapy

Donald R. Reimer, M.D., Jagan Mohan, M.D.,
and Subramoney Nagaswami, M.D.

Abstract: A relatively new etiological type of iatrogenic, hyperpyretic crisis is presented and the pathophysiology of this syndrome is discussed. This paper presents a depressed patient who was taking a tricyclic antidepressant, an aliphatic phenothiazine, and also an antiparkinson type drug. In addition to the drug therapy previously indicated, the patient was allowed uncontrolled exposure to mid-summer heat that precipitated a hyperpyretic crisis in this relatively poikilothermic patient. The treatment of this type of patient is presented to point up the fact that death is an imminent feature of this iatrogenic phenomena. Furthermore, treating physicians will hopefully avoid this type of polypharmacy.

A highly malignant form of hyperthermia is an ever present threat during "summer heat extremes." It is widely known among psychiatrists that neuroleptics interfere with temperature regulation.[1] However, of recent origin, is the polypharmacy technique "in vogue" in which depressed patients are often placed on a tricyclic antidepressant along with a phenothiazine to control agitation, accompanied by an antiparkinson drug to control disturbing extrapyramidal symptoms.

Because of the frequency of antipsychotic, antidepressant and antiparkinson drugs being prescribed in combination, a real hazard to patient welfare is apparent. The mechanism of hyperpyrexia is somewhat different for each class of drugs and the effects are additive, if not synergistic, for the heat dyscontrol syndrome.[2, 3]

All phenothiazines of the aliphatic, piperazine, and piperidine classes as well as thioxanthenes and butyrophenones are shown to be capable of abolishing the anterior hypothalamic thermal response to both heat and cold. Further it has been shown that with various antipsychotic agents the magnitude of thermal disruption generally parallels the potency of the particular drugs.[4] Furthermore, the antipsychotic drugs all have a mild peripheral anticholinergic effect.

The potent peripheral anticholinergic drugs in this polypharmacy maze are the antiparkinson drugs such as benztropine mesylate (Cogentin). Many of these drugs have an anticholinergic action equally as potent as atropine. This class of drugs contributes to hyperpyrexia by a direct inhibition of the sweating of the peripheral sweating mechanism.[5]

The antidepressant drugs seem to be roughly equipotent for depression of central hypothalamic heat control and peripheral inhibition of sweating. Combining the anticholinergic depression of the peripheral thermal regulatory mechanism with the central disruption to thermal responsiveness sets the stage for the body to be unable to adjust to high ambient temperatures.[7] These patients become, to an extent, poikilothermic and are little more able to control internal responses to heat than are reptiles.[8]

Case Report

A 41-year-old, moderately obese, white male was admitted to hospital after falling on the street during a humid, unusually hot, midsummer day. When first seen the patient was comatose and responsive only to deep pain. The physical examination revealed no focal neurological signs and the remainder of the initial examination was negative except that the skin appeared to be hyperpigmented, seemingly red, hot, and dry. Rectal temperature at the time of admission was 107 F. The other vital signs were within normal limits except for a sinus tachycardia of a 135 beats per minute, and a tachypnea of 40 respirations per minute. The patient's drug history was not immediately available; however, prompt symptomatic treatment was begun with intubation of the trachea by an anesthesiologist and a ventilation with a semiclosed circular system of 100% oxygen accompanied by a baralyme carbon dioxide absorber within the breathing circuit. Cooling was immediately instituted by pack-

Dr. Reimer is a third year Resident in the Menninger School of Psychiatry, Dr. Mohan is Staff Psychiatrist and Dr. Nagaswami Chief Neurologist, Topeka Veterans Administration Hospital.

ing the patient in ice and by intravenous cold Ringer's solution with 5% dextrose. An esophageal thermistor was inserted to accurately monitor temperature because rectal temperature probes frequently lag behind cor temperatures. The cold Ringer's solution was administered cautiously to avoid over-cooling of the cor and risking a cold-injury-current and possibly ventricular fibrillation. Within 40 minutes, the patient's temperature was 100 F and all cooling measures were discontinued. However, the patient continued to demonstrate a poikilothermic behavior and required mild warming procedures as his temperature continued to decline to 94 F. The patient was maintained on a thermal blanket. His sensorium gradually cleared within 30 hours and he was able to maintain a normal body temperature. He was amnesic for events preceding the hyperpyretic episode. His recovery was uneventful and the patient was discharged four days following admission.

After psychiatric records were obtained, the patient was found to be taking Elavil (amitriptyline HCL) 100 mg b.i.d.; Cogentin (benztropine mesylate) 2 mg b.i.d.; and Thorazine (chlorpromazine) 400 mg h.s.

Summary

Hyperpyretic crises are life threatening hazards in psychiatric patients exposed simultaneously to three, and occasionally more, peripheral anticholinergic and central thermal regulatory center depressant drugs.

Critical care of these patients involves an immediate attack on the thermal crisis to prevent coagulation of brain protein that occurs at 108 to 109 F. Furthermore, ventilation should be assured in deeply comatose patients by decreasing anatomical dead space and by preventing aspiration by endotracheal intubation. These victims should be given 100% oxygen to breathe because of the tremendous rate of metabolic activity.[9]

Further, these patients may be acidotic and require sodium bicarbonate. It is recommended that arterial blood gases and p^H be obtained initially with institution of treatment of these patients.

Other complications of drug induced hyperpyrexia include renal and hepatic failure, convulsions, clotting disorders, and high output cardiac failure.[10,11]

These patients in hyperthermic crisis require immediate care because death is an imminent feature of this disease process — a disease process that in many cases is unnecessary because of unwarranted polypharmacy.

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Special Articles

Teaching Human Sexuality In Family Practice Training

Lynn P. Carmichael, M.D. and Libby Tanner, M.S.W.

A weekend workshop on human sexuality was held May 18-20, 1973 in Jacksonville, Florida for the faculty and trainees of the two Jacksonville family practice residencies. Faculty and resources were drawn from the University of Miami Department of Family Medicine and the workshop was a condensed version of the week-long course given to second year medical students at Miami.

The goals of the workshop were to extend the range of the participants' knowledge of the wide variation of human sexual behavior; to assist the health professional in gaining a broader knowledge of her or his own sexuality; and to provide a basic background for further training in counseling sexually dysfunctional individuals, couples or families. To facilitate learning by the participant, each enrollee was encouraged to bring his or her "significant other" such as spouse or friend.

The format of the workshop was a balanced program of verbal presentations, audiovisual materials depicting explicit human sexual activity, and small group discussions. Specific topics included masturbation, heterosexuality, homosexuality, female sexuality, sex education and radical sex styles. This was all presented in the light of current rapidly changing societal mores and sexual attitudes.

The workshop was attended by 24 persons, approximately half of them spouses or friends. There were four faculty members and nine residents. Eight persons were unable to attend all four sessions. A shortened version of the sexual attitude and beliefs inventory developed by Herbert Vandervoort at the University of California was administered before and after the workshop. While the numbers completing the 25 questions on a five point scale were not adequate to be statistically significant there was evidence that the course resulted in some change in sexual beliefs regarding desirable personal behavior. On the other hand it was the subjective impression of the faculty and organizers of the workshop that there was a genuine softening of professional attitudes toward sexual behavior often characterized as deviant. This was borne out in the evaluation form at the end of course (reproduced less comments). See Evaluation next page.

Conclusion

A brief weekend workshop in human sexuality given to the faculty and residents of two family practice programs seemed to achieve its goal. There was a relaxation of professional attitudes and beliefs in the areas of human sexual behavior. Such an experience would appear to be desirable preparation for health professionals involved in primary care and family health maintenance.

▶ Dr. Carmichael, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami 33152.

Dr. Carmichael is Professor and Chairman, Department of Family Medicine, University of Miami School of Medicine; Mrs. Tanner is Assistant Professor, Department of Family Medicine, University of Miami School of Medicine, Miami.

EVALUATION

Will you help us by evaluating this workshop
(a) In terms of personal usefulness? (b) Potential usefulness for others?

1. Do you feel this workshop was valuable to you	personally	Yes 16	No
	professionally	Yes 13	No
2. Would you recommend such an experience to	Medical student	Yes 15	No 1
	Residents	Yes 16	No
	Patients	Yes 11	No 4
	Your adolescent child	Yes 9	No 6
	Colleagues	Yes 16	No
3. Do you think the workshop has added to your knowledge of human sexuality?		Yes 15	No 1
4. Has this broadened your viewpoint about the wide range of sexual behavior?		Yes 16	No
5. Has this changed your feelings about			
	Masturbation	Yes 5	No 11
	Homosexuality	Yes 9	No 6
	Female Sexuality	Yes 6	No 9
	Heterosexuality	Yes 4	No 12
	Other people's sexuality	Yes 11	No 5
6. Since this was a brief workship what would you like to have offered in an extended course? In relation to:			
	Masturbation	Yes 3	No 7
	Homosexuality	Yes 10	No 4
	Female Sexuality	Yes 8	No 4
	Heterosexuality	Yes 10	No 3
	Other people's sexuality	Yes 10	No 4
	Other topics please specify		

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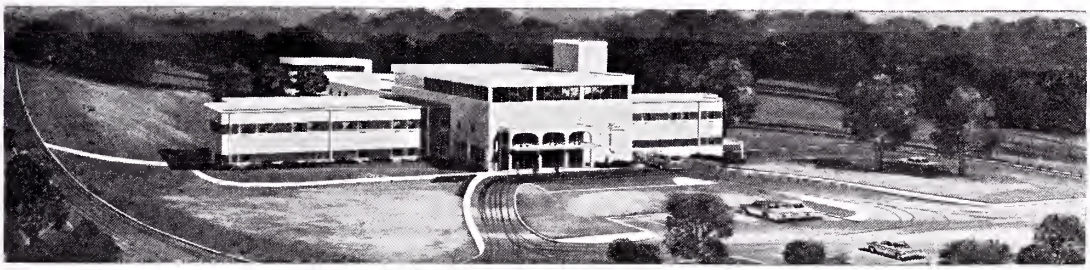

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"I Do Take Medicaid..."

Mathew E. Morrow, M.D.

The response to my brief article on Medicaid in the April issue was most gratifying and of the many letters I received only two were highly derogatory. It is obvious, however, that there is still much misunderstanding of the program and little physician knowledge of the Florida Medical Association's Relative Value Study. At this time the FMA is working on a new Relative Value Study and its Ad Hoc Committee on Medicaid is also recommending new conversion factors to the Department of Health and Rehabilitative Services. Concurrently HRS has under consideration a 12% increase in all physician payments.

A contract with a private company was signed in May for the Prescribed Medicine Program and the $20 limit will possibly be abandoned. A medical review of prescribed medication, however, will continue and both patient and physician profiles will be generated that should document trends in prescription writing in Florida.

Transaction numbers and the method for obtaining them are apparently becoming less and less a problem, but nonetheless a method to discontinue their use is being studied and even as this is being published they could become past history.

This year's annual meeting of the FMA at Hollywood recalled to me Sam Day's inaugural address ten years ago when he told the story of his young son who when given a job to do asked him: "Is there going to be any pay or is this just another job that's going to be appreciated?" The Division of Family Services is anxious for the needy of Florida and wants to assure them good medical care. The Division's staff appreciates your help. They want to pay for your services as best they can under the restrictions of our legislators and taxpayers.

Of all the specialists the pediatrician has perhaps encountered the most difficulties with our program. I personally feel that the newborn should be automatically covered for at least a reasonable period and though federal guidelines will not sanction this I think it can be done by interpolation or interpretation whichever is the easier. Certainly the physician should not be held responsible for procedural faults of the system or lack of consideration or cooperation on the part of the recipient.

Perhaps the greatest single enhancement for the program was the recent appointment of Dr. Thomas E. McKell, of Tampa, as the Medical Services Coordinator for the Secretary of HRS. His approach to governmental medicine, or better perhaps medicine in government, is refreshing and the weight of his medical knowledge is already being felt by this Division.

This article should be considered a general response to the letters received because of the brief article, "I Don't Take Medicaid . . ." that appeared in the April Journal. More specific explanations of various segments of the Medicaid program will appear in future issues of The Journal if adequate interest in the subject warrants it. I am told that well over 200 physicians became new participants in Medicaid last month and requests for provider numbers are showing a sharp increase.

No matter what happens eventually to Medicaid, whether it is swallowed up in a National Health Insurance Program or not, I feel that we must continue to strive toward its improvement, and in order to do this we need more and more medical input. In essence, we are constructing a road that others will no doubt travel.

▶ Dr. Morrow, State Medical Consultant, Division of Family Services, Department of Health and Rehabilitative Services, Jacksonville 32201.

Alcoholism, Obesity, Nicotine, Etc.

WILLARD E. MANRY JR., M.D.

There is an exciting development in the recent court decreed use of Antabuse, administered under observation, over a sustained interval. This is specified for alcoholics as alternative to a stiff jail sentence for law infraction, and it is continued for a sufficiently long interval to establish a major alteration in the reaction patterns of the subject.

Up to now, nobody has produced the solution to the problem of alcoholism. The fact that this is true is usually obscured by the vague escape explanation of "underlying problems." Our failures include obesity and smoking in exactly the same context. We go on telling people they must stop alcohol excess; overeating, and tobacco, but I have not succeeded in producing a permanent change in these things in one single patient, and I don't know of any other person who has, allowing a rare exception now and then.

It turns out that when a person truly succeeds in kicking any of these problems, it is the result of some major change in his way of life, and not the outcome of our efforts as physicians (at least not to any obvious degree). We don't like to admit this, but I think many of us are being less than honest with ourselves—or perhaps just not paying attention.

Now comes a behavioristic approach using Antabuse with a disciplinary motivation. The alcoholic now continues the intake of Antabuse far past the time we could get him to stay on it previously. He would never continue it to the point of finding other solutions on reaching an emotional impasse. Alcohol was too accessible, simple, certain, and happy a method to really look elsewhere.

Now, not permitted to return to alcohol, he has to turn to other methods, and in time establishes a much more acceptable pattern of behavior.

The court is using this presently in relatively gross situations. I have been finding it possible in several instances in private practice to apply external discipline without legal implications. These are patients with whom I have an effective rapport-usually being family doctor for many years. I pick a vulnerable period, such as right after a spree. I explain the use of Antabuse to them fully—all the aspects, including the reasons Antabuse has failed us in the past. I emphasize that at last we apparently have a final solution to the problem, but it can succeed only if they come to my office twice a week for a year or more, to swallow the medicine. And I tell them in terms to leave no doubt, that if they agree to this they must come on schedule; that if they fail to come, I will never have anything more to do with them.

We have probably wasted too much time "seeking the underlying problem." This sounds fine, but seems to assume there will be no future problems. This is likely why we have been failing the alcoholic, the overeater and the smoker.

It seems suitable to say to him, "Stop! Here is an external motivation that physically prevents further use of your present habit pattern of problem solving. You simply *cannot* use it further. There are other methods, and our best help for you will be in finding better methods. Studying the underlying problem may be of help to *you,* but we must spend our time seeking acceptable patterns to meet future problems."

Here is possibly the ultimate solution to all of our damaging behavior defects, even narcotic addiction.

We must accept the need and find a method of external discipline applicable to each category: we need drugs which pharmacologically prevent overeating, smoking, narcotic use, etc. Then a technique, preferably acceptable in advance to the patient, which gives him forcible motivation (threat of specific consequences if delinquent) to help him through the interval of conditioning and re-establishing his response patterns.

Here is a realistic point of view. It assumes human imperfection and deals with it as such, instead of trying to build, from within, a state of mental adjustment unattainable to most people.

▶ Dr. Manry, 417 Eleventh Street, Lake Wales 33853.

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Our membership, the orchestra that played the score
The officers determined the key
As we blended our tones, we performed like a symphony!
Our state has been filled with the Sound of Music
A song in our hearts for what was to be
Our lives have been filled with the Sound of Music
Composed by—you and me.

Yearbooks and phonebooks and Standing Committees
Fall Board that meets in our interesting cities
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These are a few of my favorite things!
Executive Board meets and President's memos
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FMA President "together we sing"
And he is one of my favorite things!
When my letters are unanswered
When I'm feeling sad
I think of our purpose and all we accomplish
And then I don't feel so bad.

Dough—for scholarships and fun
See—our membership is strong
Me—I'll lead you one by one
So—you'll understand my song
Cookbooks, tours that travel far
And our smashing Fall Bazaar
Citrus shipments, seafood, too,
And the Christmas Cards that bring us back to
I H A and F M F
A M A — E R F, too—
F A M E F , no less
Legislation, L E G S to you,
Health Careers, W A / S A M A groups
Mental Health and Drug Abuse
Give our blood and S O S
Counties sing your song that's best—
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—Mrs. Wm. Hugh Mathews (Mary Ann)
President, WA/FMA 1973-74

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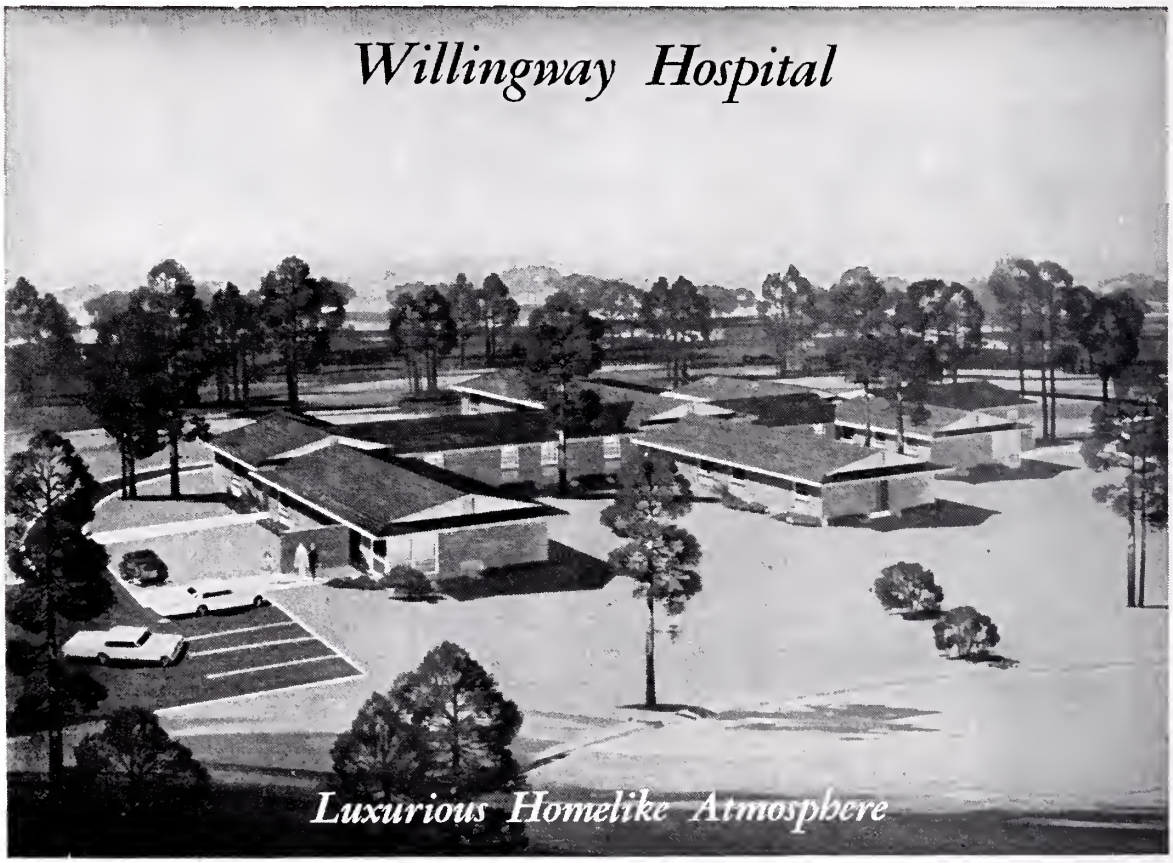

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® BLUE SHIELD

Blue Shield and the Catfish

I. B. Harrison, M.D.

This note is my swan song for JFMA Blue Shield editorials. At the risk of being maudlin, it will be a personal testimony.

As a Blue Shield board member for the past five years, I thought that the Florida Medical Insurance Trust coverage plan was an excellent one for FMA members. I encouraged my colleagues to participate and defended the plan on the floor of Reference Committee V. It was my feeling, however, that this really applied to people other than myself.

About eight months ago, a salt water catfish fin and my patella accidentally came into contact. This subsequently resulted in an ugly pseudomonas osteomyelitis involving the knee joint and tibia, necessitating hospitalization for about 11 weeks, five operations ending in a knee fusion, and total disability for over six months.

Medical expenses have so far been in the $15,000 range, and I am happy to report that my FMA Blue Cross-Blue Shield coverage came through and picked up most of the tab. Although I realize that there are limitations on certain Blue's contracts, the FMA can be assured that staff and board are constantly trying to improve all policies for the mutual benefit of the patients served and the doctors of Florida.

The FMA Blue Cross-Blue Shield plan has been a godsend to me, which makes it easy for me to urge sincerely that all FMA members take advantage of our own excellent health insurance coverage.

Also, beware the catfish!

▶ Dr. Harrison, 1433 Miccosukee Road, Tallahassee 32303.

Dr. Harrison has served on the Blue Shield Board of Directors for the past five years.

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Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monifial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

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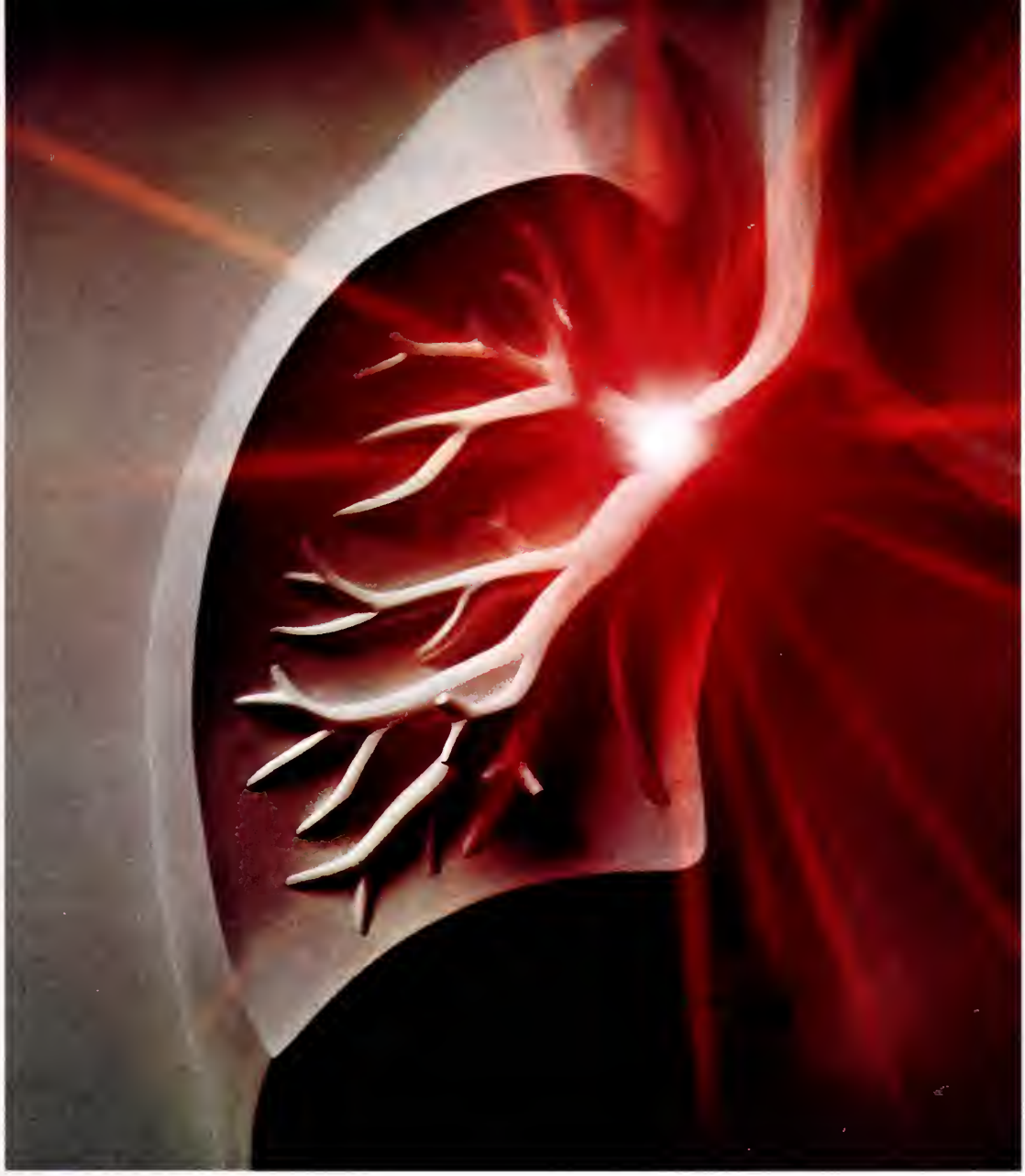

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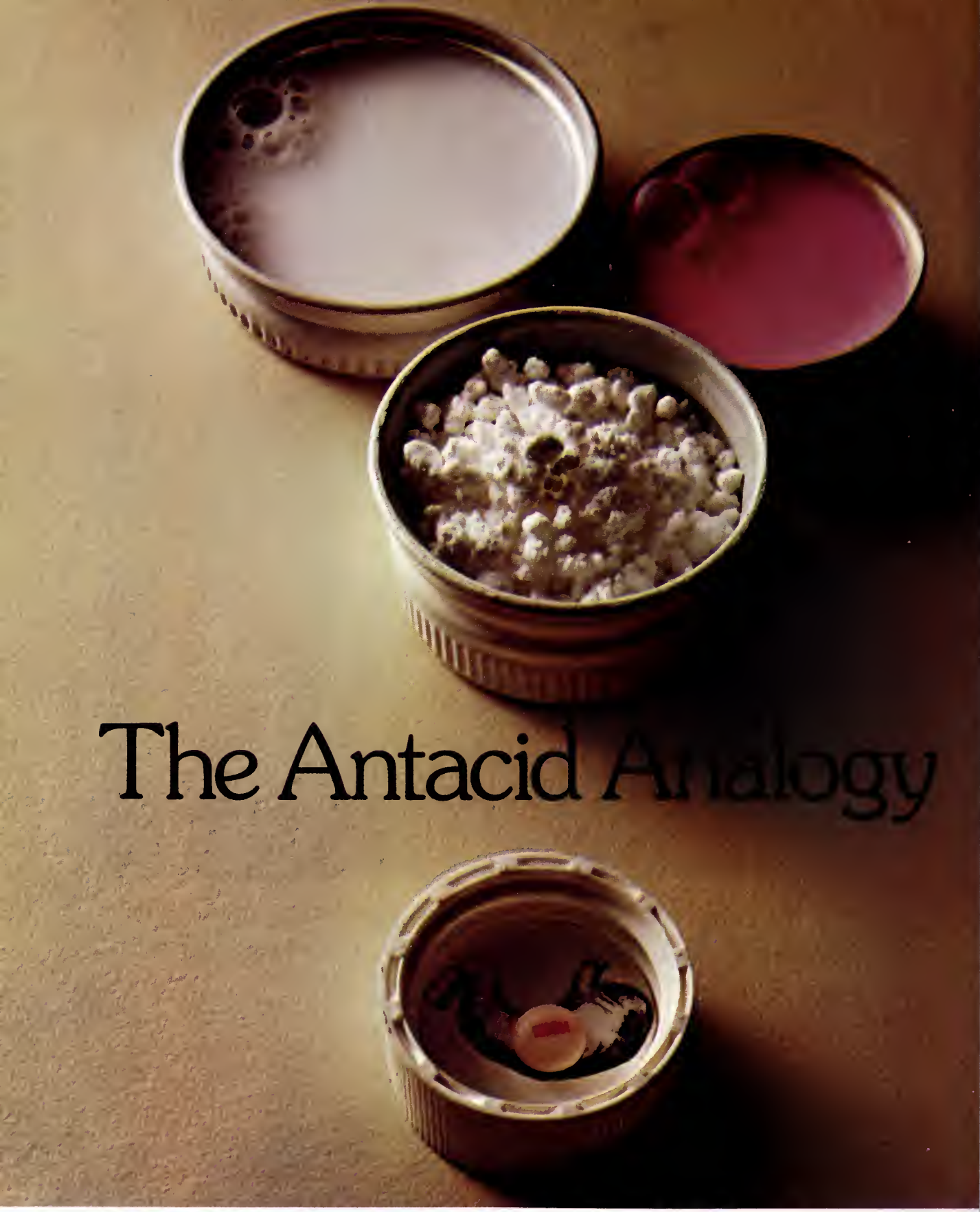

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may

Therapeutic comparisons in peptic ulcer.

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Pro-Banthine helps relieve pain. Pro-Banthine relieves ulcer pain by reducing gastric secretion and the motility and spasm of the gastrointestinal tract.

Pro-Banthine reduces acidity without subsequent acid rebound. The capacity of Pro-Banthine to reduce the secretion of total and free acid in the stomach has been demonstrated in scores of studies. None has demonstrated any significant evidence of acid rebound.

Pro-Banthine activity lasts about six hours. The effect of a single therapeutic dose (15 mg.) of Pro-Banthine lasts about six hours.* Pro-Banthine P.A.®, the prolonged-acting form, is active from 8 to 12 hours. Thus Pro-Banthine may be used to suppress acid, spasm, and pain around the clock, even during the sleeping hours when antacids, to be effective, must be taken almost hourly.

*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

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occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not **use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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*Serum Potassium Level Drops During Long-Term Exercise, *Medical Tribune*, July 4, 1973.

†No implication that 'Dyazide' is useful in preventing K^+ loss in athletes is intended.

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Editorials

PSRO Showdown

By the time this appears in print, the annual AMA meeting has become history and the anticipated opposition to PSRO did not persuade the House of Delegates to change the stand seeking amendment rather than repeal of this controversial legislature. Much before then, leading primary care groups such as the American Society of Internal Medicine, the American Academy of Pediatrics and the American Academy of Family Physicians had favored cooperation with the law, on the assumption that cooperation would direct the thrust of the law toward performance review, not cost review, stimulating physician involvement; for working models are proving feasible and repeal is unrealistic.

Optimal utilization of a hospital is one cornerstone of quality control yet opponents of PSRO see the physician acting as a government employee, in effect, assisting at his own intellectual and professional enslavement. The real issue, however, is that the AMA and the national specialty organizations are allowing themselves to be threatened, divided and perhaps destroyed by questioning participation under a law that, reduced to its basic elements, cannot be called all bad. By this law, the government is seeking assurance that the health care it pays for will be effective, efficient, economical and professionally acceptable in quality. What some physicians are asking is not repeal but an amended law to make it more responsive to the needs of patients and the profession. To them it appears that if physicians decide not to participate in PSRO, federal bureaucracy will obtain its assurances, effectiveness, efficiency and economy from someone else. While there are those who say the secretary will do this anyway, conceivably, if this did happen, the government would be confronted by a profession which, if united in participation, would obtain more support from an aroused electorate than if we had fought tooth and nail to repeal the law. When such assurances are reviewed in the context of an impossible but likely national health insurance plan, covering all citizens; the importance of immediate and direct physician participation in PSRO development becomes all the more obvious. At the present time, it is just as much a part of the law of the land as the federal constitution and how can we preach defiance of the law and at the same time, maintain the role of leadership? On the premise that federal bureaucracy occupies an adversary position, negotiations should not be abandoned, for to do so cuts off all communications and treats them as enemies.

PSRO is having someone looking over one's shoulder, an extension of what has been going on for many years in hospital tissue committees, utilization and records review committees. While PSRO "norms" may be more strict, this will make some doctors realize their own deficiencies as well as make easier the onerous chores of physicians sitting on audit committees. What must be fought for is that PSRO's remain truly practitioner peer groups into which the fiscal agents for government and federal bureaucrats cannot intercede. Why should one object to being judged by one's peers as long as the judgment is conducted by a set of rules that apply to everyone as opposed to "gut" judgment or testimonial opinions subject to the mood of the reviewer at a particular moment!

With third party intrusions into hospital record rooms to photostat complete patient charts, physicians no longer can guarantee absolute confidentiality, yet in the best interest of our patients, we should continue to protect confiden-

tiality in every possible way. As to the confidentiality of medical audit in PSRO, the law is dependent upon precedent. The first case is yet to be tried because the first PSRO has yet to be established, so, by working carefully to make sure that regulations in the first cases come out correctly, a tremendous service can be done to the patient.

Malpractice claims may be increased if PSRO processes interfere with the physician-patient relationship for it is common knowledge that any breakdown in this relationship, whether caused by the physician or by third party interference, is the root of many malpractice claims. On the other hand, the basic PSRO purposes of assurance of quality and cost reduction suggests minimization of the malpractice risk. While it is not the physician's obligation to prove himself innocent, particularly in front of his patient, yet medicine has the responsibility to protect patients against substandard performance; however, the most stringent precautions must be taken against the communication of unsubstantiated findings or interferences. Such interference with the physician-patient relationship is not in the best interest of patients or physicians, and should be the responsibility of any peer review.

PSRO is part of the trend toward consumerism that has affected almost every profession and was enacted as the Bennett Amendment to the law because of medicine's inability to police itself. Medicine has tried to do this but not very successfully. Tissue committees, therapeutic abortion committees, record room committees, utilization review are examples but lack objectivity, thoroughness and authority. Recently, self assessment examinations, re-certification and re-licensure efforts have been steps in the right direction but from the legislators' viewpoint, are too little, and too late. Because of the huge slice of the health care pie the government has bitten off, it is demanding cost and quality accounting, not piecemeal or half-hearted but effective across-the-board review of the whole system. It would be naive to expect that the government would not demand this. So, PSRO's were designed to make physicians stand face to face with critical peer reviews requiring a physician to review his colleagues hospital practice by predetermined standards to differentiate inadequate from good care. The doctor practicing good medicine, and charging reasonable fees has nothing to fear from PSRO.

Historically, the AMA began as a peer review organization 125 years ago, because the practice of medicine was deplorable. Diploma mills, primitive licensure and illiterate doctors were common. Membership in the AMA could be obtained only by educated physicians who had professional ethics, for its main purpose was to encourage professionalism. Now, over a century later, what is the medical profession doing about the bad apples, the small percentage of doctors who exploit patients, and who are in the practice of medicine solely to make a large income? With the advent of Medicare, an incentive was provided to the doctor by paying him for each procedure but not for the things that really count, for compassion, for listening to the patient, for reassuring him and for talking to his family. So, PSRO could easily be subverted into a cost control system, over-emphasizing the punitive aspect rather than the potential for improving performance and self-education. Yet if local physicians with local practice-experience interpret the law, the professional integrity and responsibility of the physician will be protected. Should the program be implemented by federal doctors, lacking practical experience, the opposite may be true. PSRO removes the utilization and quality level decision process from the vested interest control of third party payers and assists doctors to better withstand the pressure for over-utilization from both patients and hospitals in order to be better gatekeepers to the community's medical institutions.

Repealing PSRO would remove our voice from the accountability process. So rather than repeal, should we not work for an amended law as an innovative system in which the object is to improve medical care, not to crucify doctors? This is being done now by all major specialty organizations. Proper peer review, to which there is universal agreement and which is here to stay, should include the following elements: It should be available while therapy is in progress, not after the fact. Whenever possible, it should be consultative rather than punitive. Practicing physicians, rather than health care theorists or administrators, should have the last word. Finally, it must guard against pitting available dollars against quality care. Peer review through PSRO gives physicians a mandate to exert leadership; conceivably it could be our last opportunity to do so.

C.M.C.

Voluntary Price Controls

Many physicians felt they were existing in an economic vacuum under federal wage and price controls. Like other fee-for-service producers, they felt the squeeze of spiraling costs for goods and services, but were unable to keep abreast of the cost of living increase.

With expiration of wage-price controls there is a natural tendency for those previously under control to over-react and quickly regain the losses felt during the past months.

President Nixon stated in a public address on May 20, 1974 that expiration of controls has "left the country unprotected" against health care cost increases. In the past two and one-half years these costs have risen 20%, he said, and he predicted physicians fees alone will rise 22% in the next year.

During fiscal year 1973, $94.1 billion were spent on health care in the United States, up 11% from fiscal 1972. However, the gross national product rose 10.9% in 1973, and health spending remained 7.7% of the G.N.P. This amounted to each person spending $441 on health (direct payments averaged only $132). Spending rose 10.7% for hospital care but only 8.5% for physicians' services.

The climate for National Health Insurance (NHI) is growing in certain circles. It is clear that legislators will react to voter sentiment through health legislation if such is the case. It seems apparent that bureaucrats and "fiscal watchdogs" will train their eyes upon physicians for the next several weeks or months re: price increases. Should we over-react, I'm certain the media will be flooded with "white papers," graphs and statistics concerning skyrocketing physicians' fees and the urgent need for controls through National Health Insurance.

To me it seems prudent to relate our increased charges to the cost of living indices and restrict ourselves to no more than 10% this year. While physicians must react to inflationary pressures, let's not let the "hide go with the hair" and help implement the health schemes now pending.

I firmly believe our health system is delivering to the vast majority of Americans. Admittedly certain changes are necessary and certain populations require alterations in their health systems. This does not justify the complete uprooting of the finest standard of health delivery the world has ever known. Let us support sensible adjustments where indicated. Let us voluntarily restrict our fees in relation to the cost of living index and proudly tell our story to the people. It is not only in the public interest, but in our own rational self interest that we consider this matter.

Vernon B. Astler, M.D.
FMA President-Elect

Drug Substitution Law in Effect

A law passed by the 1974 Florida Legislature facilitating the substitution of "generic equivalents" by pharmacists is now in effect.

The legislation authorizes substitution with the approval of the prescribing physician. It provides that each pharmacy display a sign as follows: "Consult your physician concerning the availability of the least expensive drug for your use."

Also, the law requires that each prescription blank bear the following phrases:

Substitution allowed _____

Prior approval required _____

If the physician initials either phrase, the pharmacist may substitute a less expensive medication.

Medical Care for the Sexually Assaulted

There has been an alarming increase in crimes of violence in which victims require emergency medical care. Not the least is forcible rape where the victim may have physical injury, psychic trauma, exposure to venereal disease or potential undesired pregnancy. Physicians become involved with these diagnostic and therapeutic emergencies which result from unforseen combinations of circumstances and necessitate immediate action. They are required to exercise their best judgment and to render the standard of care for which they are legally obligated. Already published are the proper procedures and requirements for the physician to protect the interests of the patient, of justice, and of himself.[1] When followed, these medical guidelines provide for total patient care involving history, physical examination, collection of laboratory specimens, preservation of evidence, prevention of disease, pregnancy and psychic trauma, and after-care.

How can we best meet these established standards of medical care? Theoretically an experienced obstetrician-gynecologist is best qualified to deal with matters pertaining to diagnosis and treatment of genital injury and the prevention of venereal disease and pregnancy as well as proper documentation of information which may, at some later date, play a significant role in removing a dangerous sexual assailant from our society. In well populated areas with centralized medical facilities such a cadre can exist to provide a complete continuum of care. Elsewhere most patients will be brought to emergency rooms of nearby hospitals. A pragmatic approach is for an emergency room physician, frequently a full-time individual, to care for such patients when obstetricians and gynecologists are not readily available. If the emergency room physician would undertake treatment of patients from an automobile crash he would have no legal, moral, or ethical grounds to refuse treatment of a sexually assaulted patient who may, on occasion, suffer similar or worse blunt injuries.

The physician who renders emergency service to the community, for which he certainly should receive adequate compensation, is at legal peril should he fail to live up to accepted standards of care. He should not, for example, suture a facial laceration in a sexually assaulted victim and adamantly refuse to carry out the balance of his other medical, ethical, and legal obligations. Refusal would render him liable for damages resulting from his deliberate omissions. Physicians should be ever mindful of the consequences of conduct unbecoming to the profession. It is needless to fear becoming a court witness as a result of treatment of a criminally assaulted victim. Adequate compensation for the relatively few times spent in court can be arranged through cooperative agreements between medical and bar societies, an accomplished fact in some areas of the state.[2]

Emergency service hospitals which enjoy tax support or exemption benefits are in no position to refuse to care for victims of sexual assault. Attendant adverse newspaper publicity is most embarrassing. The public will lose faith in the ethics and capabilities of such institutions. Adverse newspaper publicity in one county of the state has already cast serious reflections upon medical and hospital professionals.[3] Adherence to the standards of care previously mentioned would have readily prevented such unpleasantries.

References

1. *ACOG Technical Bulletin Number 14*, Amer. Coll. Ob. Gyn., Chicago, July, 1970.
2. *Professional Guide for Physicians and Attorneys*, Dade County Medical Assoc., June, 1970
3. *Final Grand Jury Report*, Circuit Court of the Eighteenth Judicial Circuit, in and for Brevard County, Florida, Oct. 4, 1973.

▶ Joseph H. Davis, M.D., Miami.

The wisdom of the wise is usually an uncommon degree of common sense.

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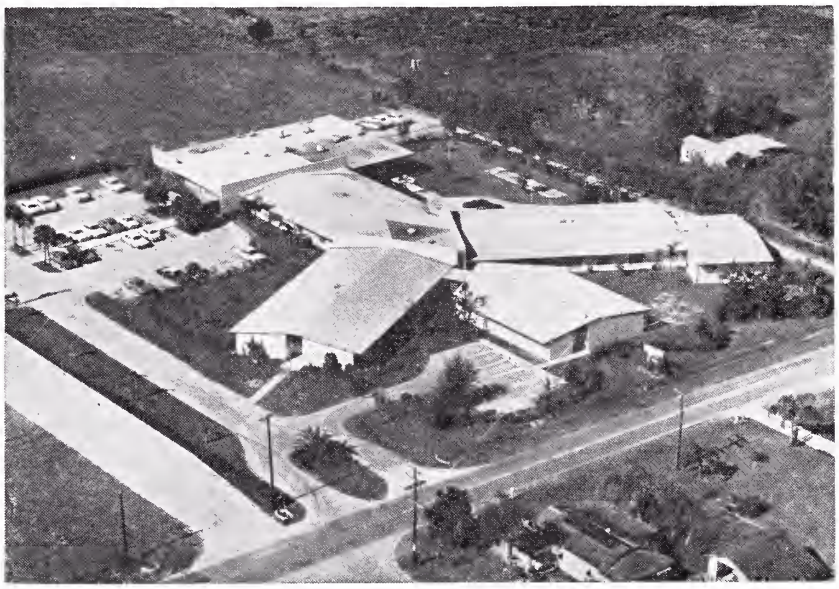

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Book Reviews

Moral Dilemmas in Medicine, a course book in ethics for doctors and nurses by Alastair B. Campbell. 214 pages. Price $2.80. Churchill-Livingston. Distributed by Williams & Wilkins Company, Baltimore, 1972, paperback.

This textbook gives a basic introduction to moral and ethical problems in the practice of medicine. The chapter on current problems deals with the ethics and morality of abortion and human experimentation. Also discussed are human transplantation and death and dying. The appendix contains the Hippocratic oath, the Geneva Convention Code of Medical Ethics, the International Code of Nursing Ethics, and the Human Experimentation Code of Ethics of the World Medical Association—the Declaration of Helsinki.

This would be a valuable resource book, especially for teachers of physicians, nurses, and medical-social workers.

F. Norman Vickers, M.D.
Pensacola

The Chinese Art of Healing by Stephan Palos. 237 pages. 50 Illustrations. Price $1.50. New York, Bantam Books, Inc. 1972.

This book, now published in hard cover and paper book, published originally in German, is a well-researched comprehensive indepth study of the traditional Chinese medicine, written by Stephan Palos, a Hungarian-born Sinologist and former physiotherapist turned Buddhist monk. It is touted as "the most informative book on Chinese folk medicine in the English language."

The book is divided into two parts: Part one dealing with the general principles with which it is essential to grasp before individual methods of therapy can be understood. The historical development and intellectual trends which were the factors for the spread and continued development of the Chinese art of healing are discussed. Acupuncture is described in detail together with diagrams of its 722 acknowledged points, symmetrically distributed over both halves of the body along 14 major lines called meridians and 8 special meridians. Nine groups of causes of illnesses are given, among them the weather elements (wind, cold, heat, fire, dampness), epidemics, emotional states (joy, anger, worry, anxiety, fear, grief, shock), physical upsets and states of exhaustion, excessive sexual activity, injuries, visceral parasites, poisoning and hereditary factors. Traditional diagnosis approximates that of present day history, physical examination and conclusions from various differential diagnoses. Therapy is divided into "lesser" and "greater" methods; the former consisting of heat treatments, emetics, laxatives or diuretics, while the latter methods are acupuncture, moxibustion, respiratory therapy, remedial massage, physiotherapy, and in certain cases, cupping as well. Preventive medicine, being an age old tradition in China, is mentioned in passing.

Part two deals with the traditional methods of treatment, together with their modern interpretation. Further discussion of acupuncture (stimulation with a needle) as "an aid to physical harmony and thus restoration of health" is done—tracing its history through written scientific accounts in Asia and Europe. Direction, technique and application of acupuncture in the 10 classification of diseases by system makes it the best part of the book.

Other forms of treatment are described, namely the Moxa treatment (consisting of encouraging organic harmony with the use of red-hot iron rods and rolled leaves of medicinal herbs); Respiratory Therapy (basically breathing exercises and gymnastics); Remedial Massage; Physiotherapy and other healing processes (such as with the use of cups, hydrotherapy, praying, surgery and dentistry). Traditional medicaments (herbs, animals and mineral origins) are listed with expected results. Analysis of results of therapy is included.

The bibliography and list of special sources are impressive and indicate the profound research the author had undertaken in writing this book. There are more than 50 illustrations, the most interesting of which are those of acupuncture points along major lines called meridians.

The author closes the book with the admission that competent experts would and should treat the submitted data "with critical reserve"—but at the same time hoping to have pointed out the possible future advantages inherent in the revelation and application of a school of medical thought based on practical experience covering several thousands of years.

T. D. Bonzon, M.D.
Jacksonville

Review of Medical Physiology by William F. Ganong, M.D. 6th ed. 578 pages. Illustrated. Price $9.00. Los Altos, California, Lange Medical Publications, 1973.

W. F. Ganong, in collaboration with other physicians, has written this 6th edition of the Review of Medical Physiology. Ganong is Professor of Physiology at the University of California School of Medicine. His previous Review of Medical Physiology was in 1971 and this edition is an attempt to bring it up to date.

Covered in eight chapters are Physiologic Principles, the Physiology of Nerve and Muscle Cells, Functions of the Nervous System, Endocrinology and Metabolism, Gastrointestinal Function, Circulation, Respiration, and Formation and Excretion of Urine. Also furnished are tables of atomic weights, Equivalents of the Metric, United States and English measures. There is also a short table of normal values in human whole blood, plasma, or serum.

The book is designed to provide a concise summary of human physiology which medical students and others can supplement with current bibliography. In view of the wide advances being made in physiology, it is impossible for one book to contain all the information; therefore, this book does serve its purpose and one can look further in the references at the end of the chapters if more details are desired.

The book is priced at $9.00 and contains 578 pages. I feel that this book is worth having in the physician's library for the times when he may want to check on some point of physiology.

Perry A. Sperber, M.D.
Daytona Beach

The First Five Years by Virginia E. Pomeranz, M.D. with Dodi Schultz. Price $6.95. 241 pages. Garden City, N.Y., Doubleday and Company, Inc., 1973.

In the introduction to this readable and likable book, the author, through her collaborator asks, "Why, then, another romp through the rigors of rearing preschoolers?" It is true that the number of books, tracts and articles written for parents of this age group is legion, but there are very few that can match this one in its "commonsense" and "easy to follow" advice.

Most physicians caring for children will not agree with all of Dr. Pomeranz's premises, but they will applaud her for her matter of fact and sensible guides to raising a small child. Her approach is low key and middle of the road in most areas. She has tried not to explore in depth any one subject but rather to give concise and easily followed advice about almost every problem that may confront a new parent. An appendix contains suggestions for reading material for those who wish to explore certain areas further.

By today's standards this book is not too expensive for young parents, and I believe it will be useful for most of them. One chapter is entitled "What to do With the Time You've Saved," listing some of the things parents might do with time saved while taking common sense suggestions in the text. The authors might have added a list for the child's physician who deals with these parents.

CORNELIA M. CARITHERS, M.D.
JACKSONVILLE

Human Sexuality by AMA Committee on Human Sexuality. 299 pages. Chicago, American Medical Association, 1972.

In the sexual-social revolution of the past decade both the public and the medical profession have been bombarded by a wide variety of "How to—" books. Human Sexuality is another one of these books, only it is a hybrid in that it is neither an ass or a mare, but a little bit of each. It is designed for members of both groups or, as the jacket states it "is an indispensable guide for physicians and the lay public alike." Like oil and water, the two don't mix well in textbooks.

The consultants (authors?) range from that hearty perennial, Mary S. Calderone, M.D. to a few obscure medical students (Mrs. Arlene C. Levin, Mr. Richard E. Shanteau, et al.) and one doesn't know who wrote what chapter, but you can be sure a Lemon (Richard C., a free-lance author) was at the bottom of it all (no pun intended).

On Page 30, someone (author, authors?) discusses sex chromosome anomalies such as Klinefelter's and Turner's syndromes and "other chromosomal abnormalities and mosaics involving supernummerary X chromosomes" which is hardly the layman's cup of tea, yet, in the Glossary of the same book someone insults the physician's training by defining words like amenorrhea, cervix, coitus, hysterectomy and premature ejaculation. My belief is that the gap between physician and layman is too wide for them to share the same book.

Although it is surprising a volume of this topic has no illustrations, it appears to cover, even though summarily, human sexuality and its parameters such as Family Planning, Methods of Coitus (although only 27 lines are devoted to such an important subject as Foreplay), Problems of Male Sexual Response, Contraceptive Counseling, and the Premarital Examination. Naturally, the high priests of sexuality, Kinsey and Masters are liberally quoted.

A particularly available part of the volume is Appendix IV consisting of 36 pages on Law and Medicine. This section discusses abortion, liability for unsuccessful birth control, minors and contraception, treating a minor for venereal disease and many other questions which are of great importance in today's society.

ARTHUR F. SCHIFF, M.D.
MIAMI

Dr. Thompson's New Way for YOU to Cure Your Aching Back by Jess Stearn. 203 pages. Illustrated. Price $7.95. New York, Doubleday & Company, Inc., 1973.

The author of this book, Jess Stearn, writes the introductory chapter, and then Dr. Alec Thompson, an Osteopath in California, takes over. The doctor's philosopy is that all backaches, whether they be cervical, lumbosacral or even secondary to disc herniation, have as their etiology a sacroiliac displacement resulting in disturbance of the spinal architecture. For this he has devised one simple exercise which he describes frequently in his book which aleviates all back discomfort. Most of the chapters deal with testimonial type descriptions of various clinical syndromes relieved by this exercise. His thesis is somewhat credulous until he gets into clearing sinuses and migraine headaches with the exercise. His last chapters deal with rejuvenation exercises to increase the circulation to retard baldness, sexual impotency, arthritis and other diseases of the aging. His other main premise is that ice, never heat, should be used on acute ligamentous muscular injuries.

I find backache to be one of therapeutic dilemma for the practicing physician. I feel that Dr. Thompson's exercise has some merit if used with limitations in mind. With other controversial treatment modalities such as acupuncture coming to our attention, I feel that his exercise will not do any harm once treatable medical conditions have been ruled out, and certainly will probably have a beneficial psychological effect on the patient.

CHARLES A. DUNN, M.D.
MIAMI

The Big, Fertile, Rumbling, Cast-Iron, Growling, Aching, Unbuttoned BELLYBOOK by James Trager, 572 pages. Price $15.00, New York, Grossman Publishers, 1972.

This is a sequel to a best seller by the same author entitled THE FOODBOOK. When I looked at the size of this book and perused its table of contents—examples, parasites are discussed in a chapter entitled "Toll of the Freeloaders" and digestion is considered in a chapter entitled "Must Have Been Something You Ate," with a chapter subheading called only doctors say 'flatus'!—I wondered how anyone would have the *chutzpah* to cover all these subjects in such a breezy (no pun intended) fashion. He had it, and he did it.

There were a couple of minor factual errors I discovered in reading but an ambitious work such as this could be expected to have many more. Good sections cover the vitamin supplement controversy and fad diets. In the two pages devoted to Weight Watchers International, Inc., I learned that "the Queens housewife, who in her late thirties dropped from 214 to 142 on a high protein diet obtained free from the New York City Department of Health, has become a millionaire." The author feels that Weight Watchers' methods have been both safe and effective, though most of the dieters would be healthier if they exercised more.

The report of the botulism outbreak from the Bon Vivant cannery was succinct, interesting, and informative.

It is well indexed. We may keep it around the office for patients who ask, "Should I take vitamins?" or "What's this I hear about cholesterol?"—thereby saving our own time and patience. Although written humorously for the layman, physicians, their spouses, and office staffs may enjoy reading sections of The . . . Bellybook for the sheer fun of it.

F. NORMAN VICKERS, M.D.
PENSACOLA

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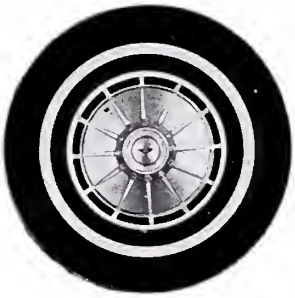

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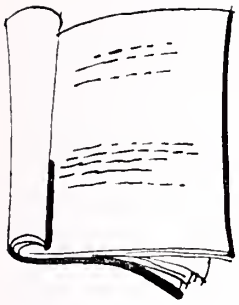

Others Are Saying

Leadership

If the medical profession is to have an important role in the delivery of health care in the coming years, it has much to learn concerning the exercise of leadership. "Organized medicine" is a group of fragments which frequently have little or no relationship or communication with one another. Examples of this include the fact that the hospital leadership usually does not communicate with its members, or to another hospital's staff, nor does it communicate with the county medical society. County societies frequently do not communicate well with their members, nor do their members feel that the society speaks for them. State medical organizations and national organizations have equally poor contact with the county societies. Evidence the problems the AMA has had over this, including its last meeting and the fight over PSRO between the delegates and the AMA leadership.

Little wonder that in our communities the non-physicians who endeavor to solve the complexities of health care delivery marvel at the lack of unity among physicians. This encourages the formation of health care delivery systems with only token medical representation, e.g., the current attempt to form a HMO by Prepaid Health Plans, Inc.

The primary force in health care delivery has now become the hospital, and the average physician is more involved in and responsive to his hospital(s) than to his own medical society. Yet it is interesting to see how the hospital management systems have carefully kept the physician in a minor role, subjecting him by constitution to a board of trustees without the privilege of membership on that board. Similarly, the Joint Commission, obviously an instrument of hospital management, has pushed far beyond the original concepts of organization of medical staffs, records, etc., and now exhausts our strength over a multitude of trivia that masquerades as quality control of medicine, yet I would wager that each of our area hospitals have different forms of compliance with the Joint Commission "guidelines." A mixed blessing of PSRO may be that at least there will be some "standards of care" which will be applied to a given region and will put peer review on a better footing for the physician, the reviewer and, most important, the patient.

Look how the lack of communication between hospital staffs and the medical society hurts all of us. A physician may be removed from the staff of hospital A (and we all know how much is involved in doing that) yet he continues to practice at hospital B till he again gets into trouble and the whole process is repeated. Similarly, a physician may be investigated by the medical society and the only way it learns that the physician was disciplined by a hospital staff is by chance word of mouth . . .

Finally, an informed membership, united and loyal to an effective leadership can and should turn to and involve itself with the forces in our community who seek to add to our abilities to deliver the best possible health care to our people. Fragmentation must cease and leadership must be grasped by us—time is running out.

ROBERT E. MCCAMMON, M.D.
TAMPA

Reprinted from the Editor's Column, Hillsborough County Medical Association Bulletin, February 1974.

HMO—A Viable Concept?

I suppose the time has come to comment on an area that has piqued the attention and concern of most well informed physicians. I am referring to that new development on the scene of medical care delivery—the Health Maintenance Organization. Possibly the most incisive commentary on HMO has appeared in *The New Yorker* magazine in a filler excerpt from the *New York Times*. The writer describes HMOs as prepaid medical groups that enroll large numbers of people who pay fixed annual premiums and are provided with medical care whether they need it or not. To this, *The New Yorker* commentator sardonically appends, "Say ah, dammit!"

The HMO experience is not new; it has been on the medical scene since the late 1920's. We have only to recall the experience of the Kaiser-Permanente group on the West Coast, the HIP Plan in New York City, and several other such prototypes to put the current HMO thrust into proper perspective. The thesis is a laudable one: to keep people well and prevent disease, thereby reducing the health care cost. Emphasize preventive periodic checkup, immunizations, and ambulatory care and you will forestall expensive hospitalizations. Remove the incentive for physician overutilization in ordering unnecessary tests or inappropriate or unduly long hospital stays, by exacting a financial penalty to be borne by the physicians responsible. In theory these objectives look good. Pragmatically, however, there are many chinks in the HMO armor.

A basic fallacy in the philosophy of the health maintenance concept is that as physicians, we simply cannot maintain the health of an individual. We can guide, we can strive, we can teach—but it is up to the individual himself to maintain his own health. Barring genetic aberrations and poor protoplasmic structure due to hereditary influence, the bulk of disease arises from factors over which the physician has very little control. Poverty, ghetto life, malnutrition, broken homes, air and water pollution, unemployment, alcoholism, etc. are all factors that generate disease and cannot be controlled by periodic health examinations. These are societal concerns that must be dealt with on levels other than those within the province of the physician as such. We cannot prevent heart disease (other than rheumatic), cancer, stroke, or the other degenerative processes. As for maintaining an individual's health, it must be apparent to any but the most uninformed and illiterate that pursuance of basic hygienic practices is the way to go. As Dr. Anne Somers emphasized in the August 1973 issue of *Prism*, we in this country are given to excesses. Our patients overeat, overdrink, overtranquilize themselves, speed excessively on highways, overwork and underexercise. They have been barraged with "how to keep well" messages via all media ad nauseam. If they look to HMOs for further education along these lines, this job might well be undertaken by paramedics, nurses, and others in allied health fields.

Now, as to detecting disease in its incipient state we can make a case for periodic checkups, but does this warrant an expenditure of from $600 to $700 per family annually? Does it warrant also an expenditure of countless hours and repeated office visits generated in some measure by the bombardment of media information warning of "danger signals"? In the lumpless, bumpless, totally asymptomatic working adult, how often is a checkup really necessary? Will a two dollar surcharge on office visits, as proposed by a local HMO in process of formation, really deter the worried well and the hypochondriac from seeking medical attention that they really don't need? This state of affairs bears the seeds of a human energy crisis that may adversely affect both the physician and the patient.

I concentrate on the worried well because these are the individuals the HMO must enroll to remain financially solvent. It is disadvantageous for the HMO to accommodate the chronically ill, the poor, and the maimed, since these groups have problems which, if cared for properly, would rapidly escalate the HMO's costs, thereby obliterating profits, unless the premiums are raised to prohibitive levels. To enroll these individuals at an acceptable premium rate and still assure profits, would necessitate underutilization of requisite service, thereby effectively compromising the quality of medical care offered the patients. So it is possible to foresee a situation wherein quality of medical care may well be sacrificed as

quantity of medical care is demanded both by the sick and the well.

There are other areas of concern that are emerging with the development of HMOs in our community. Problems are arising relating to unethical advertising and enrolling of prospective applicants wherein time-honored ethical principles are being violated. Are we to experience a repetition of the shoddy and abysmal practices that have characterized the enrollment of individuals in a few HMOs servicing MediCal patients in California? Were this to occur it would be to the discredit of the entire medical profession in our community. Will we as taxpayers be saddled in the future with the subsidization of HMOs that cannot financially exist without help despite possible exclusion of the poor and chronically ill?

In my opinion, these are some considerations that should make us take pause when we evaluate the HMO concept and its potential role in the overall system of health care delivery in our community.

MAURICE H. LASZLO, M.D.
MIAMI

Reprinted from the President's Page, Miami Medicine, February 1974.

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**Bradford, Gilchrist, Union*					
Bay	Henry C. Smallwood, Panama City	Adrian A. Rivard Jr., Panama City	1st Tues.	—	48
Brevard	Robert S. Seelman, Melbourne	Daniel Roberts, Rockledge	2nd Tues.	18	183
Broward	James B. Perry, Ft. Lauderdale	Anthony J. Vento, Ft. Lauderdale	4th Tues.	156	791
Capital	Robert P. Johnson, Tallahassee	Robert N. Webster, Tallahassee	2nd Mon.	16	133
Charlotte	Fred P. Nisi, Port Charlotte	Stephen R. Roddy, Charlotte Harbor	3rd Mon.	1	47
Clay	Raleigh Thompson, Orange Park	E. Charlton Prather, Orange Park	2nd Mon.	1	38
Collier	Nicholas Kalvin, Naples	Charles J. Montgomery, Naples	3rd Wed.	2	71
Columbia	Nilton A. Lima, Lake City	Royce Williams, Lake City	3rd Wed.	1	19
Dade	Pedro J. Greer, Miami	Marshall F. Hall, Miami	1st Tues.	403	2,235
DeSoto-Hardee-Glades	E. J. Schmierer, Arcadia	Kayum Mohammadbhoy, Arcadia	1st Tues.	7	16
Duval	Sanford A. Mullen, Jacksonville	Yank D. Coble Jr., Jacksonville	1st Tues.	30	605
Escambia	Henry M. Yonge, Pensacola	C. Fenner McConnell, Pensacola	2nd Tues.	30	180
Flagler				—	6
Franklin-Gulf	John W. Hendrix, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	—	6
Hernando-Citrus				—	36
Highlands	J. W. Osborne, Avon Park	J. Culpepper Brooks, Sebring	3rd Mon.	3	31
Hillsborough	H. L. Williamson, Tampa	John K. Petrakis, Tampa	1st. Tues.	103	476
Indian River	John H. Terry, Vero Beach	Edwin L. Lindsey, Vero Beach	3rd Tues.	9	49
Lake	Bergon F. Brokaw, Leesburg	H. Pratt Carter, Leesburg	1st Wed.	—	65
Lee	H. Quillian Jones, Ft. Myers	Warren E. Hagen, Ft. Myers	3rd Mon.	31	116
Madison	William J. Bibb, Madison	Julian M. DuRant, Madison	1st Tues.	—	6
Manatee	Joseph F. P. Newhall, Bradenton	Walter B. Graham, Bradenton	4th Tues.	11	101
Marion	Steve H. Gilman, Ocala	James L. Stone, Ocala	3rd Tues.	12	62
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Seminole	Nicholas Pastis, Sanford	Carlos Ruiz, Altamonte Springs	3rd Tues.	1	40
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Taylor	John H. Parker Jr., Perry	John A. Dyal Jr., Perry	Last Fri.	—	9
**Dixie*					
Volusia	Thomas L. Wells, Daytona Beach	Richard Dillard, Daytona Beach	2nd Tues.	3	175
Walton	Thomas G. Spence, DeFuniak Springs	Edgar H. Myers, DeFuniak Springs	3rd Tues.	—	9
			Total	1,310	8.089
			Grand Total	9.399	

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PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccousukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

FAMILY PRACTITIONER OR INTERNIST WANTED to join newly formed clinic in newly developed ITT community. Full or part time. Excellent opportunity for retired physician to supplement income. Financial arrangement flexible. Write or call: Jack Dunn, M.D., 4 Carol Court, Palm Coast, Flagler Beach, Florida 32036. Phone (904) 445-3868.

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situations wanted

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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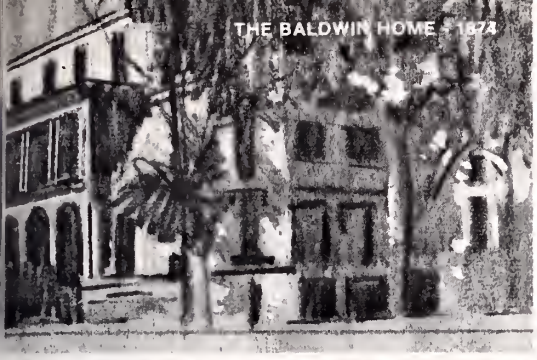

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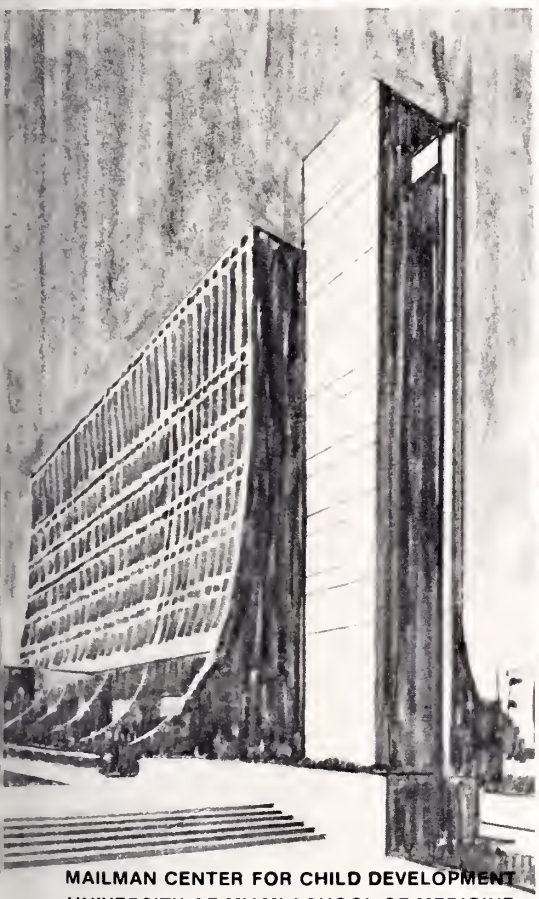

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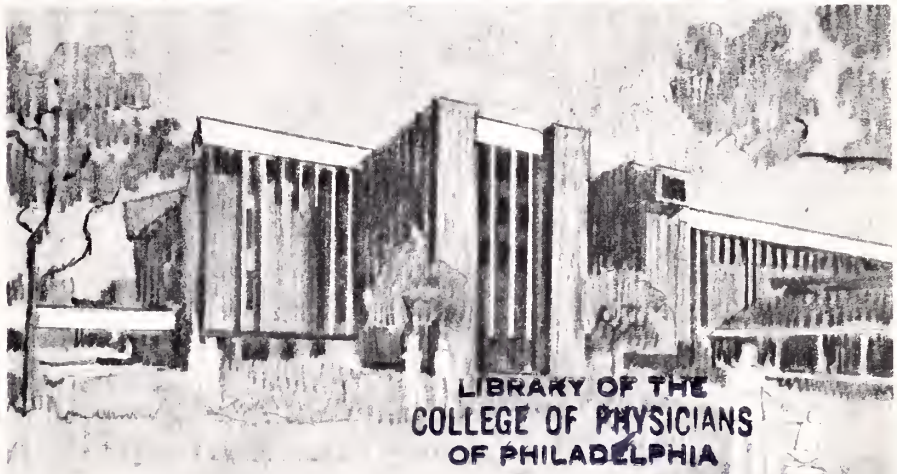

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Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive [illegible] or agitation; symptomatic [illegible] agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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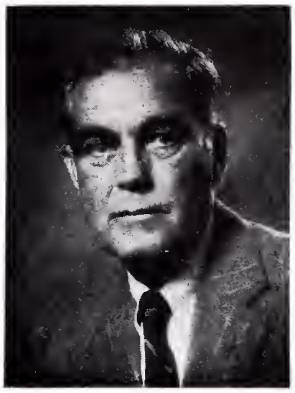
August Cover—(Upper left) The Baldwin Home where first meeting of FMA was held in 1874; (Upper right) Shands Teaching Hospital, University of Florida College of Medicine, Gainesville; (Left) Mailman Center for Child Development, University of Miami School of Medicine, Miami; (Right) University of South Florida College of Medicine, Tampa; (Bottom) Florida Medical Association, Inc. headquarters, 1974.

President's Page



Time to Think

Summer is a time for rest and relaxation, chinch bugs and mosquitoes, outings with the children and vacation with the family. It is a time to collect our thoughts and to weigh them, a period when professional organization activities interfere but little with normal routines. I look forward to the season and enjoy the rest.

I hesitate to spoil your summer, but there are challenging problems which remain for our consideration. They require our concern. The decisions reached will have a continuing influence upon the practice of medicine.

Fee adjustments will have to be considered. We must keep in mind the federal government's belief that changes will be unreasonable; so much so that they will precipitate an early decision by the Congress for strict control within a National Health Insurance plan. Each of us, deciding the course that is appropriate for himself, must consider the influence of his action upon all physicians.

If there is no indication that PSRO will be repealed at the end of this year, what will the Florida Medical Association do? Physicians have an option to form such an organization within two years. This period soon will be drawing to a close. If we are to offer an effective alternative we must have a better model as evidence and it must produce results. Lacking an alternative we must develop a physician-controlled program or allow a designated non-peer group the opportunity to develop a program.

Current legislation presents a cause for concern. Although it has not yet been funded, a School of Optometry has been approved by the legislature. A proposal to do away with statutory requirements for a Division of Health was narrowly defeated by a House committee in the 1974 legislature. Some such plan probably will be resubmitted in the 1975 legislative session.

Paul Rogers has joined Dr. William R. Roy of Kansas to present HR 12053 to the Congress. In effect it establishes a statewide controlling body for medical matters. Medical services and physicians would be administered as a public utility.

These—and other problems—will not go away.

In this summer season, then, when perhaps life's routine becomes a little slower, I hope you will become knowledgeable in these areas of concern and be prepared to use your energies to arrive at intelligent solutions.

Thad Moseley

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estrogens Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estrogen complex in the proportions found in its natural source. And for more than thirty years PREMARIN has enjoyed an unparalleled record of clinical efficacy and acceptance.

PREMARIN. The only estrogen preparation available that contains natural estrogens exclusively and also meets all U.S.P. specifications for conjugated estrogens. Assurance of quality for you and your patients.

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BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. **7352**

PREMARIN®

BRAND OF **CONJUGATED ESTROGENS TABLETS, U.S.P.**

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

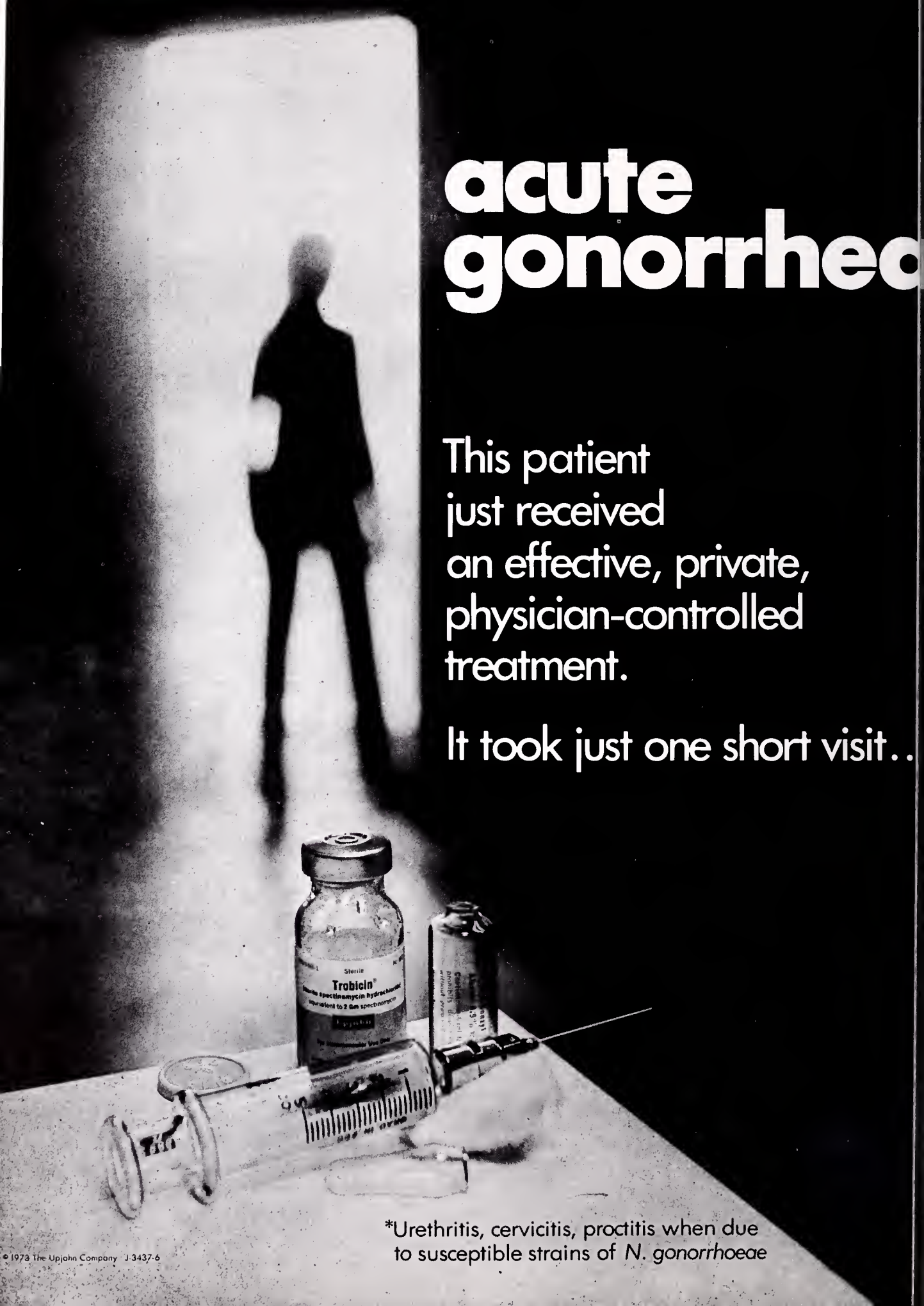
Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

acute gonorrhea

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit..



*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

© 1973 The Upjohn Company J-3437-6

Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-5 (MBR-I)
The Upjohn Company, Kalamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

Studies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains are known to be resistant, routine sensitivity testing is recommended.

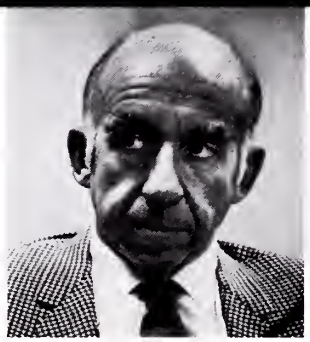
The Role of the Detail Man

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.

Dr. Willard Gobbell
Family Physician
Encino, California



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in th

Opinion & Dialogue

le a Source of Information?

Yes, with certain reservations. : average sales representative a great fund of information ut the drug products he is re- nsible for. He is usually able to wer most questions fully and lligently. He can also supply rints of articles that contain a at deal of information. Here, , I exercise some caution. I usu- accept most of the statements l opinions that I find in the ers and studies which come n the larger teaching facilities. es without saying that a physi- n should also rely on other rces for his information on rmacology.

ining of Sales Representatives

Ideally, a candidate for the ition as a sales representative pharmaceutical company uld be a graduate pharmacist has a questioning mind. I don't k this is possible in every case, l so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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acity they are indeed useful; ticularly in the fact that they seminate broadly based educa- al material and serve not just 'pushers" of their drugs.

Other Side of the Coin

Obviously, the pharmaceuti- companies are not producing all . material as a labor of love— y are in the business of selling ducts for profit. In this regard ambitious and improperly moti- ed sales representative can rt a negative influence on the cticing physician, both by pre- ting a one-sided picture of his duct, and by encouraging the ctitioner to depend too heavily drugs for his total therapy. In se ways, the salesman has often orted objective reality and lermined his potential role as an icator.

: Industry Responsibility

Since the detail man must be nformation resource as well as presentative of his particular rmaceutical company, he uld be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

What does man have in common with Samson?

Neither man nor the gorilla can synthesize vitamin C. Interestingly, the slow loris, a primate much further down the evolutionary scale, can convert L-1,4-gulonolactone to ascorbic acid in its liver and presumably does not require an exogenous source of ascorbic acid.

Because man can neither synthesize vitamin C nor store most of the water soluble vitamins, these nutrients must be replenished continuously in order to maintain normal tissue levels.

Generally, this is accomplished in his daily diet. But under conditions of illness, stress, in convalescence or following surgery, vitamin stores may be depleted or metabolic demands increased.

In such cases, Surbex-T may be indicated. Surbex-T restores the water-soluble vitamins with each tablet providing 500 mg. of vitamin C plus high potency B-complex.

ABBOTT

SURBEX-T® 500 mg. of Vitamin C with High Potency B-Complex

Restores what the body cannot effectively store

403481

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Medical News

New Post at Miami

Bernard J. Fogel, M.D., has been appointed to the newly-created post of Assistant Vice President for Medical Affairs at the University of Miami by UM President Henry King Stanford.

Dr. Fogel will work closely with Emanuel M. Papper, Vice President for Medical Affairs and Dean of the School, on all matters of internal management. He also will continue to have administrative responsibility for medical education in his capacity of Associate Dean for Medical Education.

Dr. Gates Appointed

Emily H. Gates, M.D., of Jacksonville, has been notified of her appointment as an American Medical Association representative for a five-year term to the Joint Committee on Health Problems in Education.

The group is a joint committee of the AMA and the National Education Association. The Committee serves as a coordinating and liaison group between medicine and education on matters related to health of children and youth.

Dr. Gates is Administrator of the Child Health Section of the Florida Division of Health.

Dr. Farrior Elected

Richard T. Farrior, M.D., of Tampa, was elected one of four regional vice presidents of the American Academy of Facial Plastic and Reconstructive Surgery during the Academy's meeting in Palm Beach in April.

Professor Receives Award

James E. McGuigan, M.D., of Gainesville, has been named recipient of the 1974 Distinguished Achievement Award of the American Gastroenterological Association.

Dr. McGuigan was cited for research studies of peptic ulcer disease, the control of acid secretion by the stomach and for developing techniques to measure the hormone, gastrin. He is Professor of Medicine and Chief of the Division of Gastroenterology at the University of Florida College of Medicine.

Name Change

The Industrial Medical Association has changed its name to the "American Occupational Medical Association."

The group was organized in 1916 as the American Association of Industrial Physicians and Surgeon, and in 1951, it became the Industrial Medical Association. The latest name change took place on May 1 during the annual business meeting in Bal Harbour, Fla.

Named to Chair National Committee

Leighton E. Cluff, M.D., of Gainesville, has been named to head a nationwide committee to evaluate biomedical research programs supported by the Veterans Administration in VA hospitals throughout the country.

Dr. Cluff's group, the Committee on Biomedical Research in the VA, over the next 18 months will gather information on present and past VA research, seek the views of both individuals and groups to provide perspective of the role of biomedical research in the VA, and prepare a report, with recommendations, to the National Academy of Sciences.

Dr. Cluff is Professor and Chairman of Internal Medicine at the University of Florida.

Accrediting Agency

The U.S. Commissioner of Education has recognized the Council on Medical Education of the American Medical Association, in collaboration with the American Association of Medical Assistants as the official agency for the accreditation of educational programs for the medical assistant.

The two organizations have been working together on accreditation matters for the past five years.

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1. Gordon, E. E. and Haas, A., Indust. Med. & Surg. 28:217, May, 1959.

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Dean's Page

Biomedical Research — Who Needs It?

Donn L. Smith, M.D.

The medical community faces the threat, actual and implied, of regimentation, governmental regulation and the public utility mentality of some political and lay people of considerable influence.

Many of us in medical education view the problem with a concern that matches that of our colleagues in practice. Unfortunately, medical education faces a similar threat which to us, is as severe and potentially quality reducing as the problem of medical socialization is to the practitioner. I refer to the assault on biomedical research and research training which has been in progress for some time. Questions have been raised at high political and policy-making levels as to the need for research support. Part of the problem may well relate to the failure of those in medical education to create the essential understanding in the minds of policy-makers and legislators relative to the vital role of research in both the fields of education and health care. In fact, we may have neglected to articulate the essence of the problem to the practicing physician.

In terms of medical education, one major spin-off from a healthy and productive research component is the continual presence and availability of keen, questioning and critical minds in the educational establishment. That an appropriate number of individuals so equipped remain in medical education is essential to the maintenance of quality education. The validity of this concept is amply demonstrated and reinforced by the first-rate research and research training as a functional part of medical education which has provided much new knowledge, bridging some enormous gaps between what could be accomplished in patient care at any given point in time, and what has become possible thereafter. The benefits which have resulted to both the physician and patients is one of substantial magnitude.

In consideration of past lessons some examples may be catalogued in support of the maintenance of a healthy and vigorous effort in medical colleges and elsewhere. Consider as an important case in point, diabetes mellitus. A young Canadian, Fred Banting, stimulated by the death of a young friend due to "sugar diabetes" dedicated his future to the study of medicine. After graduation from medical school, as a product of an accelerated curriculum, he read a research paper in November, 1920 by the celebrated Moses Barron which led Dr. Banting to a sleepless night and a 2:00 a.m. entry in his bedside notebook of a brief protocol for experimentation concerning the pancreas. By May, 1921, he had made the requisite arrangements to acquire ten dogs, a small laboratory and a sophomore medical student, Charles H. Best, as an assistant for a period of eight weeks. On January 11, 1922, eight months later, the first patients were treated successfully with an extract developed by Banting and Best. By spring of 1922, the extract, to be known as Insulin, was purified and the flow of patients to Toronto began. The rest is medical history, the practitioner, within a period of one year was given the power to bridge a significant therapeutic gap.

As an exciting sequel, consider the work of George R. Minot at Harvard. He had the intellectual ability to apply the hypothesis of Castle to a human disease entity, pernicious anemia. His classic paper in the JAMA, August 14, 1926, provided the demonstration of the first successful treatment of pernicious anemia and led ultimately to the development of Vitamin B_{12}, the most effective and safest single curative remedy in modern medicine.

Needless to say, there are literally dozens of instances of equally important therapeutic developments which have come from the wellspring of medical school faculty research. The essential vitamins, the basic antibiotics, modern anesthetics, antimalarials, epinephrine and related compounds are but a few of the significant results of biomedical research which have accrued to the benefit of humanity.

It is conceivable, but hopefully not likely, that the practice of medicine as we know and love it, might well be destroyed by failure to produce new knowledge. To save the profession from political and social errors only to see its practice stagnated

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

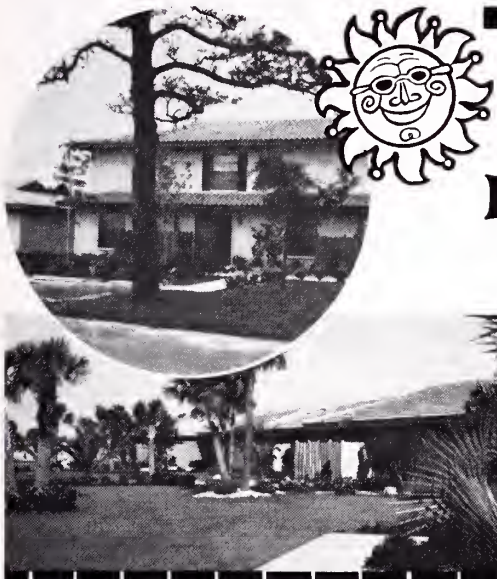
and deprived of new and life-saving knowledge would be a pyrrhic victory. We must be certain that medical research, wherever it exists, does not lose the critical mass that is requisite for the emergence of effective new knowledge of human disease, its prevention and management.

So we arrive at the base question to be answered concerning biomedical research, who needs it? Anyone who suffers or is to suffer the ravages of almost any kind of cancer, cardiovascular accidents, victims of a host of neurological diseases including multiple sclerosis, and many more who have or will acquire disease entities for which there is at present no cure and just as a world of diabetics needed biomedical research in 1921, and our children subject to poliomyelitis needed research in the 1940's and 1950's.

Last and by no means least, our colleagues in practice need research, for it is the fruits of the acquisition of new knowledge that vitalizes and extends the parameters of a productive and exciting medical practice.

One can only hope that both medical practice and research will retain all that has so clearly demonstrated to be good solutions to the problems incident to the conduct of practice and research.

▶ Dr. Smith, University of South Florida, Tampa 33620.



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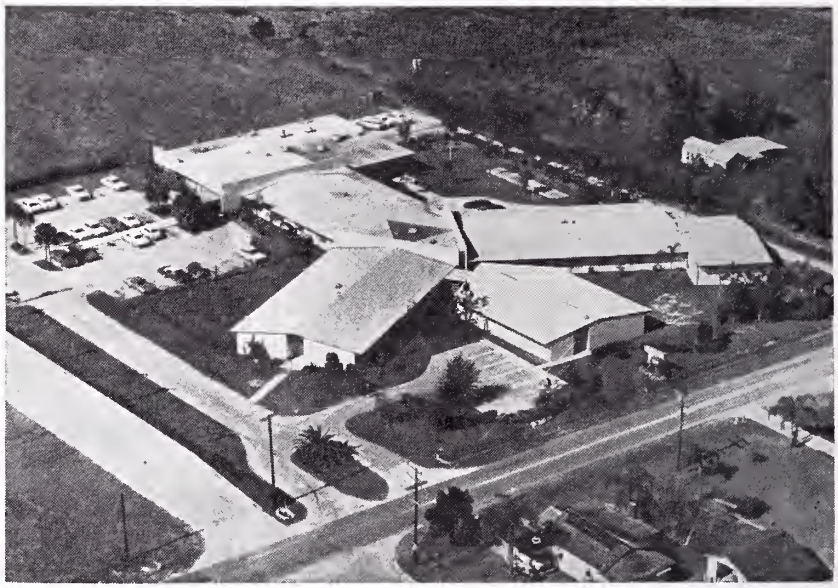

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FEEDBACK - from Pearl Street

Tetanus Toxoid Prophylaxis

Tetanus should not exist by now, but it does. Florida had 11 reported cases in 1973, tying California for the largest state total, and the nation had 88 cases. Clearly an aggressive immunization campaign should be directed toward those who have been incompletely immunized. Conversely, restraint should be exercised insofar as the "routine" booster is concerned. The fully immunized patient needs the booster only at ten year intervals. He will have a protective level of antibodies for a clean, minor wound. In the event the wound is contaminated the booster dose should be given when more than five years have passed since the last dose of tetanus toxoid. Obviously if the patient's immunization is not complete, the remainder of the series should be administered and passive protection considered with tetanus immune globulin.

VD Control—Plus & Minus

VD control shows strengths and unfortunately some weaknesses. Surveillance procedures are identifying the high risk male and female gonorrhea spreaders, treatment facilities are being upgraded, and culture screening services continue for high yield providers. Intensive epidemiology where applied in high syphilis incidence areas appears to be having dramatic impact upon morbidity. For the first time the state legislature appropriated categorical funds for VD control. This additional support together with the present staff's increased experience and maturity will greatly improve the program's effectiveness. There are some disturbing aspects. The number of gonorrhea and syphilis patients continues to increase. January to May 1974 shows a 12% increase for gonorrhea and an almost 50% increase for syphilis over the same months last year. For gonorrhea the increase is slowing down particularly among men suggesting that screening asymptomatic women produces results. Routine screening, however, cannot bring gonorrhea under control; preventive measures must be strengthened and known cases reexamined frequently to detect reinfection.

Mumps Vaccine

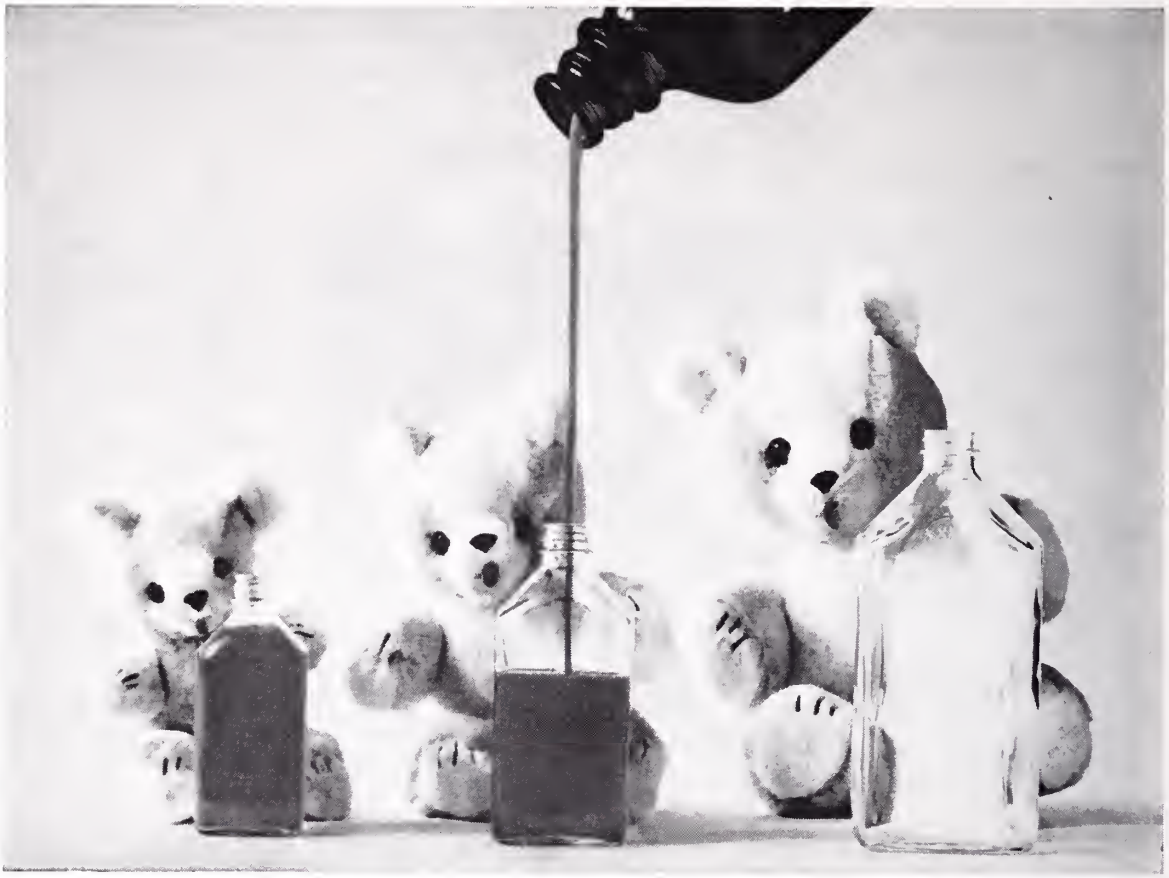
Mumps causes more children to be absent from school than all other vaccine-preventable diseases combined. More than 1,350 cases among all age groups were reported through May 1974. In the future, immunization of preschool children will virtually eliminate the disease as a cause for school absenteeism. These youngsters constitute the priority target. The mumps vaccine will be available soon in the public clinics—singly and in a combined form with measles and rubella vaccines.

Red Tide Effects

Red tides have been recognized since antiquity. Some 20 types of dinoflagellates have been implicated; three are of major importance in coastal waters of the United States and one of these occurs in the Gulf of Mexico. The last red tide developed off the Florida Gulf Coast in October last year. In November and March 1974 six human cases of neurotoxic shellfish poisoning were reported. Symptoms included numbness and tingling about the mouth and face and in the fingers and toes, difficulty in walking and muscle cramps. One patient experienced seizures, coma and respiratory arrest. All of them have recovered without residua. This represents the more rare consequences of red tide. The obvious effects are fish kill, irritating aerosol, contact dermatitis and conjunctivitis. Cooking does not appear to destroy the toxin, but shellfish beds detoxify themselves within one or two months after abatement of the red tide.

Mosquitoes and Encephalitides

Mosquitoes are likely to be abundant during the remainder of the summer and in the fall. They transmit the five major types of arboviral encephalitides known to be present in the United States. In spite of surveillance procedures, too often a human case of encephalitis is the first indication of the virus' presence. This first case is important—it triggers initiation of proper control measures. Therefore, physicians are urged to report to the local health officer all cases of suspected aseptic meningitis and encephalitis and to send serum specimens to the state laboratory in Jacksonville.



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

AUGUST, 1974 • VOLUME 61 • NUMBER 8

A Prophet With Honor

Just a decade ago the July issue of the Journal introduced its historical theme with an editorial describing past FMA presidential addresses over the years culminating with Sam Day's annual discourse on the life and times of Dr. Abel S. Baldwin. Following the untimely death of Webster Merritt it was further stated, the mantle of historian was passed to the chairman of the Committee on Archives, Bill Straight who along with Robert L. Tolle, Roland E. Wood, Clifford C. Snyder and James Ingram collected and put into print the medical history for that issue. The editorial ended with "It is the Journal's wish that this be the first of many and that every member of the Association make a permanent record so that our history can be preserved to become our heritage." The writer, Thad Moseley, editor at that time, with the help of Bill Straight saw that a historical issue appeared again in 1966 and 1967. This policy was continued in 1968 under a new editor, Franz Stewart. In each of these issues Bill Straight either wrote an article or was the guiding light who persuaded practicing physicians to take up their pens and record untold stories of the history of Florida medicine. So much interest was displayed by our readers that in 1970 another historical issue was published followed by another in 1971 and still another in 1972. With each of these issues Bill took more and more responsibility for publication and in 1973 was made historical editor of the Journal.

As the proceedings of the FMA annual meetings became more voluminous, so much more time was needed to get them into form for publishing, that this subject usurped the July issue in later years, pushing the historical issue into August where it has been an annually recurring feature. That is until last year when looking ahead to the 100th anniversary of the Association the yield of historical articles being accumulated by Bill Straight was polished and improved for a 1974 centennial issue in January. With the preliminary announcement of that issue, interest grew and writers contributed more articles than we could afford to publish while time also became a factor as papers were submitted beyond our deadline. This left unpublished some good papers which had required much time and talent to preserve our historical past. So, in spite of the increased cost of paper, publication and postage, plus decreasing revenue from pharmaceutical manufacturers; because of the interest expressed on other historical issues, this month's Journal is centered about the lives of Florida physicians of the past. To these writers and to Bill Straight we are indebted for this issue.

"Men make history, not the other way around. In periods where there is no leadership, society stands still. Progress occurs when courageous, skillful leaders use the opportunity to change things for the better," said a recent president of the United States. So, may this recitation of the past inspire our readers, as well as our leaders, to be courageous, forthright and correct in making future decisions that will affect our way of practicing medicine and determine what will be written about us by future generations of physicians.

C.M.C.

Dr. James Hall

1760-1837

Mary M. DuPree and G. Dekle Taylor, M.D.

Destined to be remembered as Florida's first physician, James Hall was born in Keene, New Hampshire, October 8, 1760. He was the sixth of eight children of Benjamin and Meletiah Hall. His father was a distinguished citizen of Keene, representing his community in the legislature and as a Revolutionary War soldier.[1]

Evolving events shaped the destiny of James Hall and the land he would later adopt as his home. During his childhood, the colonial zeal of the French, English, and Spanish was still strong after two centuries of vying for supremacy in the Americas. The French and Indian War was in progress. Ideas of freedom and resentment of oppression were growing seeds in the minds of young colonials. These would soon blossom into the Declaration of Independence, Revolutionary War, independence of South American nations from Spain, French Revolution, and War of 1812.

When Hall was three years old, the Treaty of Paris signified the end of the French and Indian War in which the English were victorious. England traded Havana, which she captured, to the Spanish for Florida in 1763. Although England occupied Florida for only 20 years, she left her usual permanent influence. Immigration, long prevented by the Spaniards, was now encouraged by the English. Grants of land encouraged settlers to remain and develop the colony. These practices were adopted by the Spanish in their later occupation at which time a land grant was made to the young physician, Dr. James Hall.

Nothing is known of Dr. Hall's childhood. He became a soldier at age 17 and enlisted in the Sixth Regiment of militia in the State of New Hampshire for the Continental Service. At age 21, he was a sergeant in the Third Regiment, New Hampshire line. He was under the command of General Lafayette, serving with Colonel Alexander Scammell's Regiment in 1781 at Yorktown, in the decisive battle against Cornwallis.[2] These war experiences undoubtedly had a very meaningful and lasting effect on him. At age 64, Dr. Hall wrote the following letter to General Lafayette after Lafayette had visited the United States in 1824.[3]

St. Johns, East Florida
October, 1824

General La Fayette Sir, Your . . . reception in the United States . . . [is] a just tribute . . . to your valor and merit . . . [and] to those who have shared the . . . fatigues and dangers with you in the field. At Monmouth I was in General Poor's Brigade, when we met General Lee retreating before the army in some disorder. —Gen. Poor, with his brigade was ordered by Gen. Washington forward to hold the British in play until he could form his army in order of battle. Never were orders more perfectly obeyed, and we gave check to the British Grenadiers led on by Sir Harry Clinton. . . . A moonlight night saved him from destruction. In 1780, I was in Col. Van Courtland's [Philip Van Courtlandt] Regiment, and Poor's Brigade. . . . In 1781, I was in Col. Alexander Scammell's Regiment, who joined you, shortly before the siege of Yorktown, and was mortally wounded: he was great in stature . . . greater in mind, and . . . lamented by Gen. Washington and all the army.

The 6th of October we intrenched . . . a little below Yorktown near the British outposts, not far from Governor Nelson's brickhouse. The 8th instant, we commenced a heavy firing on Lord Cornwallis.

All these circumstances must be fresh in your memory. . . . I hope the next Congress of the United States will give you solid testimonies of their gratitude . . . and that [you and] your family may spend your days in a land that will love and honor you as long as the name of Washington shall be remembered. . . . I am almost the only solitary individual in East Florida that has had the honor of being under your immediate command.

With all due respect,
I am your most,
Obedient and humble serv't,
James Hall

Land Possession

When James Hall was 19 years old and a Revolutionary War soldier, Spain declared war on England and occupied West Florida. She received East Florida at the conclusion of the Revolutionary War by an exchange with the British for the Bahama Islands.

No records are presently available substantiating Dr. Hall's activities from 1781, his last Revolutionary War record, to 1790, when he was known to have received a Spanish land grant in East Florida. Seven hundred and seventy-five acres near Julington Creek were granted to him by Governor Quesado on December 19, 1790.[4] Knowledge of his real estate holdings and interest in Spanish land grants suggests that land possession was an important motivating factor in his

migration to this Spanish territory. This was a land of change and uncertainty. Spain, weakened by the fervor of her revolutionary colonials in South America, had difficulty maintaining law and order. Florida became a refuge for runaway slaves, dangerous adventurers, and unruly Indians, and a new home for the dependable frontiersman as well. Speculating the United States would eventually take over Florida, Spain rightfully maintained concern for the likely expansive policies of her strengthening neighbor to the north. Imaginative citizens of the new United States migrated to East Florida, receiving Spanish land grants and purchasing property. For a while Spain encouraged the policies of immigration instituted by the English and was generous in providing land grants. Increasing concern for an eventual United States takeover led Spain to attempt to close the Florida-United States border in 1804.

What was Dr. Hall seeking in East Florida? Was his primary motivation to develop a medical practice or to obtain material possessions, or both? He was a very colorful and adventuresome individual blessed with several talents. He was enterprising, self-sufficient, and interested in his fellowman. Although nothing is known of Dr. Hall's academic pursuits, knowledge of his medical practice and other interests in Florida would indicate that he must have satisfied sufficient academic requirements leading to these endeavors.

Hall accumulated large parcels of land through grants and by his marriage to Eleanor Pritchard. Eleanor's first husband, Robert Pritchard, migrated to East Florida from South Carolina about 1783. He acquired large land holdings including a saw mill grant of 16,000 acres at Julington Creek, now a part of the City of Jacksonville. Eleanor was the daughter of Daniel and Prudence Plummer, for whom Plummer's Cove on the St. Johns River was named. Robert Pritchard owned and was the first settler of the land on which downtown Jacksonville now stands. He did not remain long, however, because of the dangers of Indian attacks. He and Eleanor moved to LaGrange, a more densely populated area on the St. Johns River. This was near the village of San Antonio. This village later became known as Monroe, and it was finally named Mandarin. The Pritchard's left their overseer and slaves to farm the plantation but they too soon abandoned it because of the Indian raids of 1812. Hall later filed an unsuccessful suit in the belief that his wife was entitled to this land in a Spanish grant of 1791.[5]

Eleanor had seven known children by her first husband, Robert Pritchard. Only four were living in 1804. He died in 1804 at age 42. Within one year, Eleanor, now age 36, married Dr. Hall.[6] They had one daughter, Eleanor, who later married Oliver Wood.[7] He built Jacksonville's first hotel in 1851, later named The Buffington House.[8] He became Mayor of Jacksonville in 1847. He is buried in the cemetery with Dr. Hall at LaGrange, now Mandarin. The Hall's daughter, Eleanor, died sometime between her marriage in 1831 and 1834, after having two daughters: Alice Jane Wood and Eleanor Hall Wood.[9]

James Hall was apparently very knowledgeable about land grants. He testified frequently before the Board of Commissioners aiding others in determining claims and titles to Spanish land grants in East Florida. His widespread testimony showed an unusually wide acquaintance throughout the county. Court records show frequent testimony by him and Eleanor to establish the claims of heirs to the property of Robert Pritchard. He is also known to have helped a Revolutionary War veteran obtain a pension from the United States Government.[10]

Florida became difficult for Spain to manage during the beginning of the 19th century. Spanish power in the world was declining during the Napoleonic Wars from which England emerged victorious. Prior to and during the War of 1812, the United States was concerned that the British would again take over Florida in order to maintain a foothold on the south of the developing nation. A spirit of aggression and land hunger was present in the United States. The United States was interested in the possible acquisition of Canada and Florida, as she was angered by the British violation of her neutrality and the impressing of her seamen on the high seas.

In 1812, President James Madison fomented rebellion in East Florida with the idea of annexing it. General George Matthews, a former governor of Georgia, was chosen by President Madison to be the leader of the Patriots War, as the movement was called. He organized a small force of citizens of Georgia and insurgents of East Florida, all hopeful of taking over this land for the United States. Many residents who had migrated to East Florida were eager to again be citizens of the United States. Most of them sought U.S. protection and stability which the Spanish government had not given them.

Florida was to be liberated by the Patriots, and the territory then transferred to the United

States. In March 1812, an abortive attempt was made by one small force of 70 men from Georgia and nine from Florida marching the Patriot flag into Florida. Military forces promised by the United States were not forthcoming. An attempt to capture St. Augustine was unsuccessful.

On June 18, 1812, the United States declared war on England, but would not support the occupation of Florida. Further abortive attempts were made by the Patriots to provide a territory to be annexed by the United States. President Madison and Secretary of State Monroe were concerned about a possible British occupation of East Florida if Spain's possession of East Florida was violated by the Patriot Rebellion. President Madison repudiated General Matthews, because of a lack of congressional support and ordered an orderly evacuation of the Patriots from Florida. In March 1813, the Patriots were withdrawn under the protection of General Pinckney of the United States Army after reassurance by Spanish Governor Kindellan of St. Augustine of complete amnesty for most of these citizens of East Florida who had participated in the Patriot Rebellion.[11]

Banishment

It is known that Dr. Hall participated in the rebellion, but little is known of his activities. He was banished from East Florida from September 18, 1810 until March 24, 1812. This information is revealed in a suit in the Superior Court of East Florida in January 1822 in which Dr. Hall sued one of the Patriots, William Craig, for $5,000 damages. Hall stated that Craig, "did craftily, falsely, and maliciously, and without any probable or reasonable cause, by various false and malicious means, cause and procure your petitioner (James Hall) to be unjustly and wrongfully arrested and denied of his liberty, and to be banished from the said province, his family, friends, and property therein, on or about the aforesaid eighteenth day of September one thousand eight hundred and ten, and to remain, continue and be kept in such banishment from the day and year last mentioned until the twenty-fourth day of March one thousand eight hundred and twelve; that the said William Craig did by the aforesaid means and without any reasonable or probable cause, also cause and procure property of your petitioner to the value of one thousand eight hundred dollars to be unjustly levied for him and carried away from your petitioner on or before the twenty-fifth day of March one thousand eight hundred and eleven in the province aforesaid, and while the said province so remained under the dominion of the said King of Spain." On January 30, 1822, Dr. Hall was granted an attachment against the property of William Craig for $5,000 damages. During his banishment he probably resided with his married stepdaughters, Amelia Bachlott and Mary Creighton, in St. Marys, Georgia, also headquarters of William Ashley who was prominent in the rebellion. His wife, Eleanor, moved to St. Augustine during this time.[12]

On April 18, 1813, he sought amnesty from Governor Kindellan. After taking the oath of allegiance to Spain, he found the governor friendly and forgiving. In a document foresworn by Justice William Ashley of Camden County, Georgia, on June 11, 1813, Hall stated: "This Deponent accepted the Pardon and took the oath of allegiance and then proceeded to enquire after certain negroes owned in right of his wife who had taken shelter in St. Augustine and was soon told by a man who had considerable influence with the populence, that no property would be suffered to be given up but on the contrary that it should all be retained to make good the damages which the people in St. Augustine had sustained during the Revolution and he further said that if the government attempted to restore the property to the Inhabitants they, the Citizens of the Town of St. Augustine, would rebell against the Governor. This Deponent also received information that his life was greatly threatened by persons unknown to him for the mere cause of being a Revolutionist- Wherefore he concluded it unsafe to say anything more respecting his property and finding that the populence undertook to rule the County he conceived it unsafe to remain in the Province and accordingly proceeded to this state for protection." He then returned to St. Marys, Georgia.[13]

The following article, published in the East Florida Herald in St. Augustine 14 years after his banishment, suggests he was quite sensitive about this occurrence.[14]

East Florida Herald. October 16, 1824.

For the Herald.

Mr. Editor—Being repeatedly asked by my new acquaintances in St. Augustine the cause of my being banished from Florida during the year 1810 the reign of the petty tyrants of the Spanish Government in this territory. To prevent such inquisitive Gentlemen hereafter troubling me on the subject, I now through the medium of your paper give them the following short answer.

In all great convulsions in nature the mountains and lofty trees of the forrest suffer more than the little and scrub below them, this is the case in human nature. In all revolutions, the malice, envy and wickedness of

petty tyrants falls on the great, the good, and the wise, whist the little vulgar falls harmless to the ground.

In England Saint Thomas Becket had to flee for his life and was afterwards murdered by villains whilst he offering up prayers at the altar of Almighty God. Henry Duke of Hereford was banished by the tyrant Richard the 2d, and was afterwards King of England by the name of Henry the 4th. In later times the dukes of Ormond and Oxford, Lord Bolingbroke and others were also banished. The great duke of Marlborough who commanded the combined armies of England and her allies for ten years in Germany who never lost a battle or laid siege to a fort that he did not gain was disgraced by a set of combined Cowards who dare not shew their heads in the field of battle at Blenheim. In France thousands of shining lights of the world were exiled for their wisdom. The great and renowned Bonaparte who made the petty kings and little tyrants of Asia, Africa, and Europe tremble on their thrones died in exile. If you are not satisfied with those great characters you may add that of your obedient, humble servant of East Florida.

JAMES HALL.

Why he failed to state the facts of his banishment is not known. This article while suggesting an egotistical temperament reveals that Dr. Hall must have been a very sensitive man who possessed a keen knowledge of historical events.

Medical Practice

East and West Florida were ceded by Spain to the U.S. in 1819, and the treaty was ratified in 1821. In June 1822, Cow Ford was founded and subsequently named Jacksonville for Andrew Jackson. Duval County was also created in 1822. Little is known of Dr. Hall's activities during this transition. Far more is known about Dr. Hall's family, military, business, and political experiences than his medical practice. He was a man of varied interests. Many historical documents refer to him as James Hall, not as Dr. Hall. In one reference he is referred to as a planter, not a physician. In his second will written in 1834, he lists himself as a physician.

Judge Farquhar Bethune, a close friend and advisor of Dr. Hall, owned the plantation "New Ross," located on the St. Johns River four miles south of Jacksonville. He kept a very comprehensive diary on the weather and happenings on his plantation. In his diary we find recorded Dr. Hall's only known medical act, the bleeding of the slave Andrew, and thus the first authentic record of the practice of medicine by a physician residing in Duval County.

On Friday, April 5, 1833, Judge Bethune wrote in his diary: "Temp. 66 Cloudy—76 Fair—72 Cloudy. Planting corn. Andrew sick . . ." Saturday 6th "T. 68 fog—78 cloudy—73 rain. Planting corn. Plowing grove. Andrew sick." Sunday, 7th "T. 73 cloudy—82 fair—78 rain." Monday, 8th "T. 74 cloudy—fair—fair. Went to Jacksonville 6 a.m. Andrew sick." Tuesday, 9th "T. fair—Fair—63 Fair. At Jacksonville. Returned before dinner with Dr. Hall. Had Andrew bled . . ." Also a previous reference on "Friday, October 8, 1830—70 Rain—74 Cloudy. Clearing land and cutting poles—Went to Dr. Hall's." "Saturday, September 9, 1830—73 Cloudy and fair—66 Fair—Gathering corn. Returned from Dr. Hall's and found William absent having rode off on Nelly."[15]

In a Territorial Paper dated March 8, 1825, a U.S. Marshal refers to James Hall three times as "Dr. Hall." Dr. Hall was charged with the illegal authorization of cutting and selling live oak trees in a Spanish land grant deeded to Robert Pritchard and now in possession of his heirs. The Marshal believed the land should have been ceded to the United States because Hall failed to build a sawmill as specified in the Spanish grant provision.[16]

On March 11, 1829, James Hall was listed as "Dr. James Hall" in the East Florida Herald, a newspaper published in St. Augustine, as a candidate to represent Duval County in the next legislative Council. He was unsuccessful in this endeavor, receiving only a limited number of votes in the June election. These are the only known references to James Hall as "Doctor."[17]

He made two known wills. The first in 1831 suggests that Eleanor, his wife was financially secure and that he willed his entire estate to his daughter, Eleanor, reserving whatever is necessary for the support of his wife should her own estate be insufficient at any time. Showing concern for his fellowman he specified that should his daughter die without children his estate be appropriated for the support of common schools in the vicinity of his residence. Eleanor died in 1832. This will was later administered after his death by his second wife, Dorothy.[18]

A second will written in 1834 bequeathed his entire estate to his second wife, Dorothy. He instructed her to give $1,000 in five $200 yearly installments for the education of his granddaughter, Eleanor Hall Wood. No mention is made of Alice Jane Wood, his second granddaughter. He mentions Oliver Wood as the father of his granddaughter and the husband of his now departed daughter, Eleanor Wood.[19]

In 1833, at age 73, in Jacksonville, James Hall married Miss Dorothy Deering of Portsmouth, New Hampshire. She is believed to have been between 33 and 40 years of age and to have owned a shop in St. Augustine, Florida. It is of interest to note that they were both from the same state.[20]

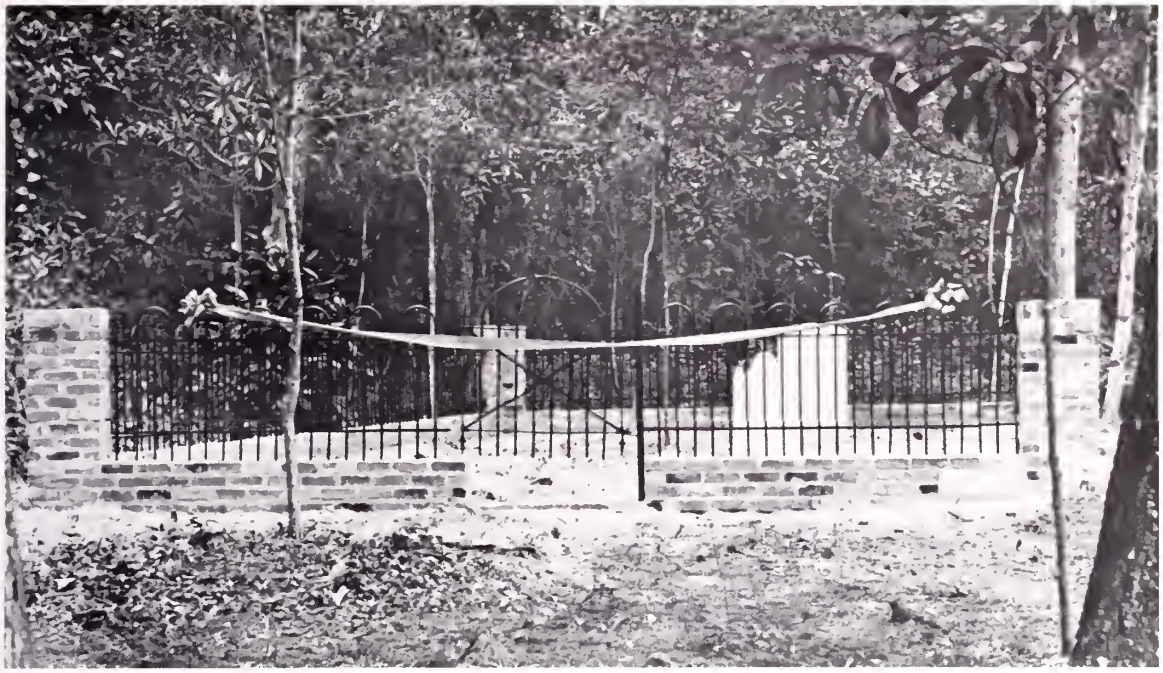
Dr. James Hall died Christmas day 1837 at age 77 years. Although other physicians had practiced for short periods of time in Florida, Dr. Hall was the first known doctor to practice in Duval County after this area became known as Duval County, and the first physician to practice in Florida following annexation by the United States. He practiced under Spanish rule for a quarter of a century. He was buried at LaGrange, East Florida, his grave being the only one in Duval County which is positively identified as belonging to a Revolutionary War soldier.[10]

After he died, reference to Dr. James Hall was largely ignored until the Duval County Medical Society Centennial year of 1953. Through the efforts of the late Dr. Webster Merritt, a trace of his history was begun and his grave was rediscovered. In 1924, the Regent of the Jacksonville Chapter of the Daughters of the American Revolution found the grave of Dr. James Hall. In 1926, through the efforts of the Daughters of the American Revolution, a marker was placed on the grave by the National Society of the Sons of the American Revolution.

Mrs. C. M. Haley gave an acre of land containing the gravesite of Dr. Hall to the Duval County Medical Society as trustee. The grave itself is located near Dr. and Mrs. Hall's old homestead at Plummer's Cove. It was originally a grant of 275 acres at Beauclerc Bluff made to Robert Pritchard in 1795.[6] On October 15, 1972, the Duval County Medical Society dedicated a restored tombstone in memory of Dr. James Hall.

Here lies the interesting yet still mysterious first physician of Duval County in the original graveyard formerly known as LaGrange, Florida, now Scott Mill Road, Mandarin, a suburb of Jacksonville.

Grave of James Hall, M.D., in 1944. (Courtesy Duval County Medical Society)



Restored grave of James Hall, M.D., in 1972. (Courtesy Duval County Medical Society)

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▶ Dr. Taylor, 221 Marshall Taylor Doctors' Building, Jacksonville 32207.

True wisdom consists of knowing how to make a point without making an enemy.

—Long Island Builder

The Florida Medical History Museum St. Augustine

James J. DeVito, M.D.

In 1565 the Spaniards founded St. Augustine, a tiny presidio settled on a little inlet on the northeast Florida coast. With Don Pedro Menendez de Aviles' expedition were two surgeons, five barbers and an apothecary. In the subsequent centuries, St. Augustine, the oldest city in the United States, developed a rich historical heritage. Equally interesting is the medical historical heritage which has been presented in a previous issue of this Journal.[1]

The first actual record of a hospital at St. Augustine can be found in a letter dated February 23, 1598 and written by Governor Gonzalo Mendez de Canzo, telling of a small frame hospital adjoining a wooden church, the Hermita de Nuestra Senora de la Soledad. This small hospital was instrumental in saving many lives—soldiers, Indians, and Negro slaves—during a fever which swept the community at that time.

This "lean-to" against the church wall served as the hospital until 1599 when it was appropriated to house Franciscan priests whose convent had been destroyed by fire. At the personal expense of Governor Mendez in January 1600 another hospital (dedicated to Santa Barbara) was constructed at another site. However, the hospital location proved to be a poor one; therefore, the Franciscan Convent having been rebuilt and the Hermita de Nuestra Senora de la Soledad having been enlarged, in 1605 the patients were moved back to the original hospital. In the subsequent centuries there were a series of hospitals in St. Augustine at various locations as fires and decay dictated rebuilding. The condition and operation of St. Augustine's hospitals from 1597 to 1790 depended largely upon the attitude of the incumbent governor. Some were interested in hospitals and the care of the sick but others apparently allowed these institutions to deteriorate with little concern. The problems of adequate patient care, administration, and lack of funds were ever present.

Dr. DeVito is Chairman, Florida Historical Museum Committee of the Florida Medical Association.

During the period 1763-1784 the British occupied the city and a Scottish carpenter-builder named William Watson purchased a stable on Aviles Street. He remodeled it for his own use until some time later when he built a new home a few steps to the southeast and his former residence became a convalescent home. This was converted into a military hospital by the Spanish government in 1791.

Medical Museum

This "Hospital Militaire" was to become one of the historical landmarks to be included in the city's vast restoration program in preparation for its 400th anniversary.[2] In 1964 the members of the St. Johns County Medical Society approached the Florida Medical Association, the American Medical Association's president, Edward R. Annis, and the AMA Committee on Archives regarding the creation of a medical museum in the Spanish Hospital. "It was felt by the St. Johns County Medical Society that a medical museum should be set up honoring the history of medicine in Florida, and in this, the nation's oldest city, throughout the past 400 years."[3] The AMA's librarian, Tom K. Mura, offered what assistance his library could give and expressed best wishes for success, and "the hope that the AMA might also be able to set up a historical exhibit some time in the future."[4]

The St. Augustine Historical Restoration and Preservation Commission set about reconstruction of the Hospital Militaire (Spanish Hospital) on its original foundation. Bearing the coat of arms of Charles IV, King of Spain during the late 18th century, over the entrance, the building's ground floor plan included the apothecary shop, morgue, doctor's office, officers' and enlisted mens' wards, and an isolation ward. The second floor rooms, as in the original hospital, were to be the living quarters of the hospital's staff.

At the 1966 meeting of the FMA House of Delegates, Dr. Jere W. Annis moved the adoption of the St. Johns County Medical Society Resolu-

tion 65-15, History of Medicine Museum, which "referred to the Board of Governors for study by appropriate segments of the FMA, necessary action and immediate implementation" of the building of a medical history museum at the Spanish Hospital. This was adopted. In August of that year the necessary committee of the FMA was appointed, local restoration authorities were notified, and joint planning was begun. The first phase was to be the careful reproduction of the first floor as it was in the 1790's. The second phase, to be accomplished over a three year period, would include 12 mural paintings depicting significant events in Florida medical history and such medical memorabilia as could be accumulated, all to be housed on the second floor and designated as the Florida Medical History Museum.

Attempts to raise money by voluntary contributions resulted in disappointment. However, the St. Johns County Medical Society pledged an initial $15 per member and the FMA Board of Governors presented an initial contribution of $1,000. In addition to these monies, five medical societies and five individual physicians contributed another $890. These funds were sufficient to purchase and costume 14 life-sized mannequins representing patients and medical staff.

Antique furniture was provided by the Restoration Commission and much of the interior carpentry work was accomplished by Dr. Carlton I. Calkin, the curator, and his young student assistant, Stephen Warner. Even before funds were made available, Dr. Calkin and Mr. Warner "had manufactured" the initial mannequin, dressed it in borrowed vestments including a pair of Steve's trousers, and displayed it on the mortuary bed in the morgue.[5] Dr. Calkin also constructed a scale model of the hospital complete with miniature patients, attendants, and instruments which was displayed at the 1969 annual FMA meeting, resulting in the donation of many artefacts which are now part of the museum.

Dedication

Finally, things were in order and the first floor was opened to the public with a dedication

Fig. 1.—Spanish Military Hospital reconstructed from 1793, contains a pharmacy, morgue, doctor's office, officers' ward, enlisted men's ward, and isolation room complete with life size figures. The second floor serves as a museum of Florida medical history.

ceremony on September 10, 1969. Dr. Henry J. Babers, FMA President, and Dr. W. Dean Steward were joined by the local physicians' committee and by members of the restoration committee and state and city officials in this ceremony. As the long awaited hospital came to life, visitors to the ancient city began to visit it in numbers and possibly to "hear the thud of solders' boots as they entered with their hapless patients or picture Travers, Bousquet and Ben moving from patient to patient making rounds by flickering candlelight on a morning nearly 200 years ago."[6] (The Spanish Hospital was visited by 44,867 people during the year 1971.)

Now that the first floor of the hospital had been appropriately appointed and opened to the public, there remained the medical museum which was to occupy the second floor. In 1970 the FMA Executive Committee requested the aid of the FMA Women's Auxiliary to raise funds for the planned murals and the completion of this museum. Auxiliary President, Mrs. A. J. Spanjers, appointed an Ad Hoc Committee to promote interest in the Auxiliary's component societies. The proceeds from the Auxiliary's Art Show in 1971 were donated and Dr. Calkin's display at the annual FMA meeting that year brought in an unexpected and unsolicited $122. The Halifax Hospital Library, Daytona Beach, and several physicians or their families, contributed a small library of early medical books (some dating back to 1690),[7] laboratory items, surgical instruments, photographs, and personal effects.[8]

A most significant and valuable addition to the museum collection was the watch which had belonged to Dr. J. Y. Porter, Florida's first health officer. Originally a gift from the City of Jacksonville in appreciation of his services during the yellow fever epidemic of 1888, the diamond and ruby encrusted watch had been given to the State of Florida to reside at the State Board of Health. In a formal ceremony at the 1972 House of Delegates, Governor Reuben Askew on behalf of the state presented the watch to the Historic St. Augustine Preservation Board to be displayed in the Museum of Medical History. FMA Auxiliary President, Mrs. Wesley S. Nock, then presented an additional gift of monies voted by the Auxiliary to purchase a dome-type display case equipped with safety apparatus and an automatic recording

Fig. 2.—View of Museum of Florida medical history.

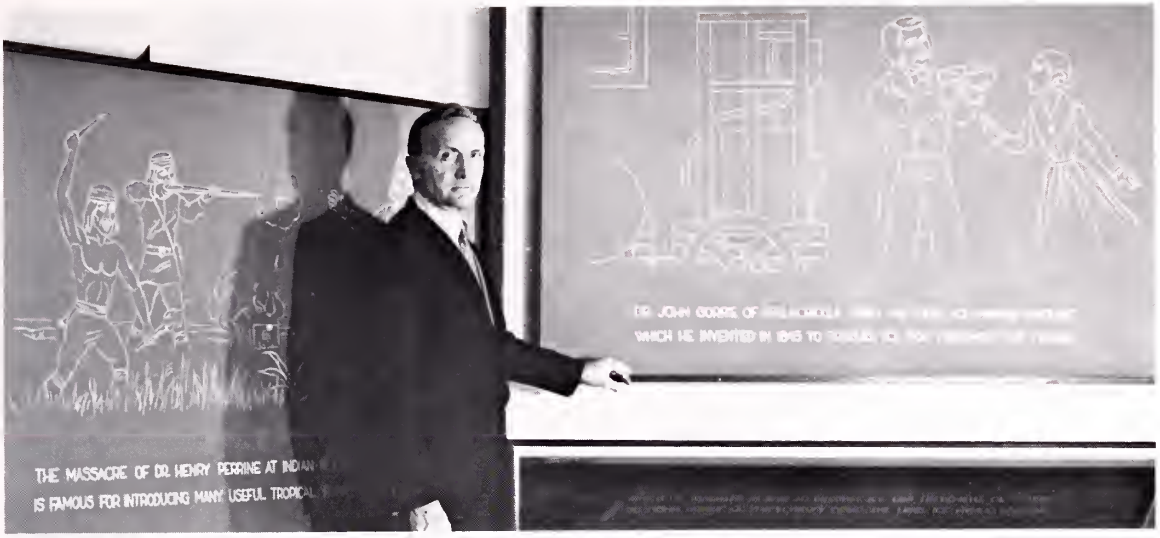

Fig. 3.—Carleton I. Calkin, Ph.D., Curator of the museum.

system which would allow visitors to hear the unique chimes and the story of the beautiful timepiece.

Many were now eager to see the museum opened but there remained problems of insufficient funds, inadequate security, maintenance, and attendants. As a temporary substitute for the planned full-color murals, Dr. Calkin offered to produce line drawings in white on colored panels, and although immersed in other restoration projects throughout the city, he began yet another "weekend project." The solution to the problems of maintenance and security came with a memorandum of agreement between the Historic St. Augustine Preservation Board and the FMA in July 1972. This agreement, when approved, placed the responsibility of maintenance, security, provision of utilities, and planning of exhibits with the Historic St. Augustine Preservation Board. In turn, the FMA agreed to continue to publicize the project and try to raise funds for the expansion and completion of the exhibit. The cost of security personnel and warning systems was to be financed in part by funds obtained from visitors' tickets.

Although Auxiliary members attending their 1972 Fall Conference received a special tour of the Spanish Hospital, the opening day was July 27, 1973. As this day grew nearer it became apparent that the showcases which had been ordered months in advance would not arrive in time. Friends were pressed into service, display cases were borrowed, and the exhibits illuminated only minutes before the museum and its small adjoining library filled with people representing the state and local medical associations, the Auxiliary, the St. Augustine Preservation Board, and city and county officials.

It is hoped that readers of this article will take time to visit the Spanish Hospital and Florida Medical History Museum and will help us by contribution of money and medical memorabilia. Inquiries and checks should be made to the Florida Medical Foundation, P. O. Box 2411, Jacksonville, Florida 32203, and checks should be marked for the Spanish Military Hospital and Florida Medical Museum. Such checks will be income tax deductible.

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3. Correspondence: James J. DeVito, M.D., to Edward R. Annis, M.D., August 7, 1964.
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7. Some of these valuable books were the donation of the widow of Dr. Herbert E. White, FMA President in 1950.
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9. Stephen Warner, a history major in college, who worked as Dr. Calkin's assistant, completed his first year as a law student at Harvard University before having to enter the Armed Services in Viet Nam. So dedicated was he to the Florida Medical History Museum project, that before his departure he willed his small savings to be sent to Dr. Calkin for use in this project should he not return. He became one of the many casualties in Viet Nam. His parents have since visited St. Augustine and the hospital/museum which had so much interest for their son.

▶ Dr. DeVito, 208 Inlet Drive, St. Augustine 32084.

Florida's First Medical Journal

Sara B. Straight

"Of making of books there is no end. And this is well. We offer no apology for launching the Florida Medical and Surgical Journal."[1] So begins the salutory editorial in the first issue of Florida's first medical journal, published in Jacksonville in November 1885. Following were issues published in December 1885, January, February, March, April, May, June, July and August 1886.

At the meeting of the Florida Medical Association in 1886, some of its members tried to make the Florida Medical and Surgical Journal the official organ of the Association, but after deliberation the majority of the members voted that it simply be commended to the "patronage of the physicians of the State."[2] At its meeting in 1887, the secretary of the Association announced that this periodical had been merged with the New Orleans Medical and Surgicial Journal and that subscribers to the Florida Journal were entitled to the New Orleans Journal.

The publication of this Journal was a private enterprise, but according to the editorial previously quoted it held high ideals for its relationship to both the sick and the doctors of the state.

"We shall labor to become the exponent of the body-medical in the State we represent, so that the stranger within our gates may be intelligently directed in his pilgrimage for health. The climatology of all localities will be honestly set forth without fear or favor, and we shall spare no effort to preserve the profession a faithful record of those cases who seek the climate of Florida for relief. To this end, we invite the hearty co-operation of the profession throughout the State. With this, our labor will be easy; without it, our mission is well nigh impossible. Brethren of the Profession—men of the rank and file of medicine—give us your assistance, and we shall do you good and not evil all the days of our life."[1]

During its existence the Florida Medical and Surgical Journal had three editors, all from Jacksonville. They were Thomas Osmond Summers, M.D.; Charles H. Mallett, M.D., and Neal Mitchell, M.D. The first two were never members of the Florida Medical Association. Dr. Mitchell was elected a member in 1884 and was still active in 1893, and perhaps later.

Editorial Board

Dr. T. O. Summers was the first editor listed on the masthead of the Florida Medical and Surgical Journal. The Journal was indeed fortunate in having such an outstanding man as the chief of its editorial board. Fortunately too, he is the one about whom we have the most biographical information. He was born at Charleston, South Carolina on November 10, 1849. He was educated at the Southern University at Greensboro, Alabama, University of London, University of Berlin and also studied theology at Edinburgh.

Dr. Summers attained rather high positions of prominence for his time; for instance, he was Professor of Chemistry and Physiology at Southern University and Vanderbilt University, and at the time of his death was Professor of Anatomy in the St. Louis College of Physicians and Surgeons. He also served as Dean of the Medical Faculty of Florida's first medical school while it briefly existed in Jacksonville.

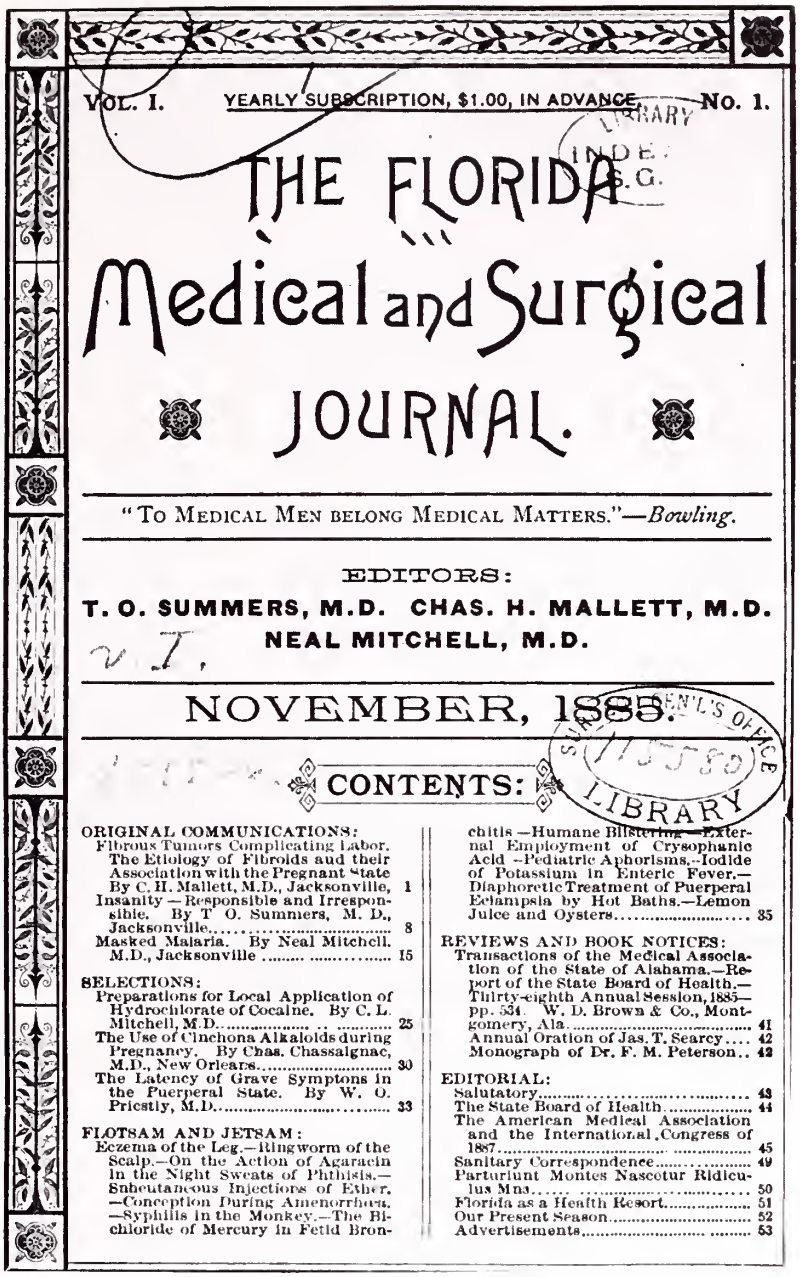
During the yellow fever epidemics in the south in 1878, 1888 and 1897, Dr. Summers served admirably. He was commissioned by the United States government twice to study and act as a yellow fever expert in South America and Cuba.

Among his scientific literary contributions were: "Summer's Yellow Fever," a pocket anatomy, and a work on physiology, plus many articles, and later he was also editor of the St. Louis Clinique.

Although not a member of the Florida Medical Association he was a member of the American Medical Association, Missouri State Medical Association and several other state and local societies.[3]

As editor of the Florida Journal, he was its most prolific contributor, producing six scientific articles in the course of the Journal's existence. Among these was "The Human Hand," a romantic dessertation on the structure, physiology and symbolism of the human hand. Dr. Summers was given to flowery rhetoric and for this reason many of the editorials in the Journal are believed to be his but, unfortunately, none of them are signed.

Dr. Summers committed suicide on June 19, 1899, by shooting himself in the head. Reflecting his depressed state of mind is a pathetic and som-



VOL. I. YEARLY SUBSCRIPTION, $1.00, IN ADVANCE. No. 1.

THE FLORIDA Medical and Surgical JOURNAL.

"To Medical Men belong Medical Matters."—*Bowling.*

EDITORS:

T. O. SUMMERS, M.D. CHAS. H. MALLETT, M.D.
NEAL MITCHELL, M.D.

NOVEMBER, 1885.

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ber poem written just before his death. The closing lines read:

> The grave, at least, gives rest from troubles here,
> And we may hope for sweet oblivion there.
> Then, Charon, come! I signal thee tonight,
> Come row me over the Styx, I've lost life's fight.[4]

Perhaps indicating his hesitancy to perform the deed he was about to commit, on the reverse of the sheet he repeated a line from his poem:

> And yet it is an awful leap to take
> into the great unknown.[5]

The second editor, Dr. Charles H. Mallett, was graduated from the Medical School of Harvard University in 1880.[6] He contributed one article to the Journal, "The Diagnosis of Sex Before Birth." He apparently practiced obstetrics for he mentioned his experience at the Boston Lying-in Hospital.[7]

Also contributing one scientific article, "Masked Malaria," was the third editor, Dr. Neal Mitchell. Born in 1855, he graduated in 1880 from the Long Island Medical College[8] and among other things served as president of the Duval County Board of Health during an epidemic of smallpox in Jacksonville in 1883.

As a personal friend of Dr. J. Y. Porter, the first State Health Officer, he saw with Dr. Porter the first case in which a firm diagnosis of yellow fever was made in Jacksonville during the catastrophic epidemic of 1888. During that epidemic, there was established a refugee camp seven miles

west of the city which was named after Dr. Mitchell.[9] He died of tuberculosis at his summer home in Readfield, Maine, in 1911.[10]

The Journal was initially printed by the Times-Union Printing and Publishing House in Jacksonville. In the May, 1886, issue on page 305, it is noted that the publishing office "has been removed from the Times-Union to K. C. W. De Costa's Printing House, corner of Pine and Bay Streets in Jacksonville. Under our present organization, we hope to have the Journal in the hands of our readers on the first of every month."[11]

A yearly subscription to the Journal cost but one dollar. It is interesting to note that even at this low price the Journal did not survive.

Journal Contents

The contents of the Journal were organized under the following sections:

1. Original Communications: original medical articles; addresses by persons of national as well as local prominence; letters to the editors, etc.
2. Selections: papers, speeches and lectures given to various medical groups.
3. Flotsam and Jetsam: a collection of varied short articles on medical subjects.
4. Editorials: many varied subjects, not necessarily medical in nature.
5 Dots: miscellaneous notes and announcements.
6. Meteorological Records: these were from the official observations of the Signal Service, U.S.A.
7. Our Advertisers: it should be noted that the Journal highly recommended its advertisers: "We would direct the careful attention of all our readers of the Journal to our advertising pages. The progressive practitioner cannot afford to pass them by, since all preparations herein advertised are recognized by the profession as standard ones."[12] This is in marked contrast with today's medical journals which accept no responsibility for the products they advertise. Examples of frequently appearing advertisements are: Goodwyn's Compound Syrup of Hypophosphites with Lactates and Pepsin, Tarpon Spring's Sanitarium, Bromidia by Smith and Co., Liqueur Coco by Warner and Co., and Calder's Liquid Beef Tonic.
8. Later there was added a section: Reviews and Book Notices.

Only one article in the brief existence of the Journal had an illustration. This was a pen and ink drawing in the article, "Cure of Spinal Caries," by Columbus Drew.[13]

In all the issues of the Journal were frequent articles about Florida as a health resort. In one issue the author states: "It is a remarkable fact which we have observed from extensive experience that all wounds heal more rapidly under the climatic influence of Florida than we have ever known elsewhere. Ulcers are more amenable to treatment, and the residents of Florida seem to enjoy a remarkable immunity from them. Remedial agents act more promptly, and with more decisive effect; the types of disease are milder, and, in fact, the whole physical organism seems more flexible under treatment here than in any country on the American continent. . . . But then Florida is a second Eden—her limpid lakes and silver streams and balmy zyphyrs are free to all the world, and among her fruits and flowers grows no forbidden tree."[14]

There are also frequent articles about the "Negro Problem" from a standpoint of health. Not all the articles within this Journal were written by physicians; prominent persons in other fields both in and outside the state contributed. Indeed, there is the suggestion that the editors found it difficult to get articles from the physicians of the state for, particularly in the later issues of the Journal, there is a predominance of articles written by contributors from beyond the borders of the state.

It is regrettable that, after such a valiant effort on the part of Dr. Summers and his contributors, the Florida Medical and Surgical Journal was so short lived.

FOOTNOTE: The bound volume reviewed contained all of the issues which were published and was obtained from the National Library of Medicine, Bethesda, Maryland. So far as is known to this author, this is one of the few, if not the only, copy in existence.

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▶ Mrs. Straight, 4901 Hammock Lake Drive, Miami 33156.

Early History of Medicine in Miami Beach

Cayetano Panettiere, M.D.

Miami Beach was incorporated in 1915, but it was not until 1923 that it had a permanent resident physician. Dr. Charles Frederick Roche, a general practitioner from Bay City, Michigan, took office at the Aladdin Building. A year later Dr. Thomas B. Hall of Marshall, Missouri, joined him. Dr. Elmer H. Adkins came early in 1925.

The medical history of Miami Beach is so intimately connected with the turmoils and successes of the town that a bird's-eye view of Lincoln Road seems appropriate. The "Times Square" of Miami Beach was the corner of Lincoln and Alton Roads. At the northeast corner stood the Miami Beach First National Bank built in 1923. Adjoining it was a wooden structure which housed the barbershop at one end and a grocery store at the other. The buildings on Lincoln Road were mostly one story. Some were two. The tallest was the Fisher Building which had six stories and was occupied by the offices of the Fisher Empire. Then there was the Lincoln Hotel and across the street were two tennis courts and finally Mr. Fisher's residence on the ocean front.

We must remember that Miami Beach in the early '20s was strictly a three-month town. The "season" began in December and ended in March, after that practically everything was closed including most stores and apartment houses. Only a few sturdy residents remained to weather the long nine-month stretch until the next "season." In this environment it became apparent to Mr. Fisher and his associates that if Miami Beach was to attract the wealthy it should have a hospital to take care of the ill. Allison Island had just been pumped in and, of course, it was barren. Mr. Fisher donated the ground provided James A. Allison would build a hospital. Mr. Allison was a successful businessman but he knew nothing about hospitals and less about running them. His idea of a hospital was a plush structure, with bellboys to carry the luggage of the patients to rooms of artistic decor. The meals were prepared, not by dietitians, but by a French chef and served in special china. The hospital opened January 2, 1926 with most of the luxuries except the bellboys.

Dr. Scott Edwards was made director. He had been directing his own little hospital in Ft. Lauderdale. Dr. Arthur Walters was imported from Indianapolis to direct the medical staff. With him came three promising young men also from Indianapolis, Dr. George Garceau, Dr. Frazier J. Payton and Dr. Rankin Denny. These men constituted the house staff and later became distinguished in their own fields.

In the fall of 1925 a small group of highly trained men attracted by the new facility settled in Miami Beach, Dr. Walter Hotchkiss, otolaryngologist; Dr. E. Clay Shaw, urologist, and Dr. Cayetano Panettiere, surgeon.

The hospital had been in operation only eight months when the devastating hurricane of September 1926 struck. It did much damage, not only destroyed physical properties, but demoralized the personnel. The hospital had been operating on such a lavish scale that it was impossible for it to succeed. The town became deserted; it seemed as if everything had to be rebuilt. The real estate boom of 1925 had collapsed; the hurricane finished what was left.

The Allison Hospital, while it lasted, was well equipped. It had excellent x-ray facilities, good laboratories, and good technicians. Dr. Edwards had brought from Johns Hopkins Miss Coralie Brady to supervise the operating rooms, together with Miss Angela Pigott and Miss Emma Hallmark to direct the surgeries. It was a smooth operation and compared favorably with the then existing medical facilities. Miami itself had only one hospital of any significance, the James M. Jackson built and directed by Dr. Jackson, a man of unusual talents and great capabilities. Two other hospitals, the Victoria and the River View, were converted apartment houses.

No office space was available on the Beach, but by the good graces of John H. Levi, an official of the Fisher Corporation, and later Mayor of Miami Beach, we were allowed to occupy three rooms above the Post Office at 1133 Fifth Street. By we, I mean Dr. Shaw and myself. Dr. Hotchkiss acquired a space with Dr. Roche and Dr.

Dr. Panettiere is Miami Beach's oldest living physician.

Allison Hospital at Miami as it looked in 1926.

Walters was located at the hospital.

It is interesting to note that during the winter months the practice of medicine in Miami Beach must have appeared lucrative to doctors from the north as some practiced from hotels without a license from the Board of Medical Examiners. They were attracted by the sunshine and what seemed to be gravy while vacationing. It may have been this factor which prompted the Medical Board not to grant reciprocity. Of course, not all practitioners of medicine who came to Miami Beach were "snow birds." There were many itinerant physicians who came for short stays and were depressed by the long nine month stretch of grits and grunts.

The great depression came and it affected Miami Beach severely. The hospital was obliged to close. Father William Barry of St. Patrick's Church embarked in what seemed a gigantic enterprise. He persuaded the Sisters of St. Francis to take over operation of the hospital. A group of wealthy men came to the rescue and subscribed enough money to make the transfer of ownership. This money was later given to the Sisters. The first few years of operation was a little short of disastrous. At one time the hospital had two patients, one was a charity case. But, as conditions in Miami Beach improved the hospital became alive again. The Allison Hospital was renamed St. Francis Hospital in 1934.

St. Francis Hospital at Miami Beach in 1974.

The "season" attracted tourists but it also attracted a number of health advocates of every variety and description. They operated from hotels and in certain cases from well centered establishments. Across from my office on Lincoln Road was a lavish centre devoted exclusively to colonic irrigations. These centres became very popular and created the impression that one was not well if he did not have a colonic irrigation at least once a month. Even Bernarr MacFadden bought the decaying Deauville Hotel and transformed it into a colonic spa.

In the early '30s a few physicians preferred to weather the dismal conditions and assume the practice of medicine. On the south side of the Beach were Dr. Paul Jenkins and Dr. Herman Boughton; with Dr. Walters was Dr. D. Ward White, a promising young surgeon. Dr. G. H. Withers had taken over the pediatric field and Dr. Foxworthy general medicine and Dr. Jean Jones Perdue became associated with Dr. Roche.

The years have mellowed the temper of its inhabitants and now Miami Beach boasts of three magnificent institutions: Miami Heart Institute, St. Francis Hospital and Mt. Sinai, all engaged in the performance of the finest improvements of modern medicine and surgery.

▶ Dr. Panettiere, 1217 Banana River Drive, Indian Harbor Beach 32935.

Recollections of a Country Doctor

James Martin Anderson, M.D.

Editor's Note: The quotations of this article, unless otherwise documented, are from a personally typewritten memoir of 109 pages and certain correspondence of Dr. James Martin Anderson (1881-1952). Permission to publish these was graciously granted by the late Dr. James L. Anderson of Miami and his sister, Mrs. Margaret (Sam H.) Moorer of Tallahassee. Had Dr. Anderson envisioned the publication of his manuscript, he would doubtless have made many corrections. However, this editor feels that correction of the spelling and sentence structure would detract from the charm and vigor of Dr. Anderson's writing, therefore, editing has been limited to correcting obvious typewriting mistakes and the occasional insertion of words for the sake of clarity.

". . . As a consequence most of the surgical cases were handled in the homes of patients. My memory of one of such cases occurred soon after I began practicing. I was called to see a case that I recognized at once was an acute appendicitis. Found also he did not have any money. I sent runners to notify his brothers, thinking they might have money enough to get him in (a) hospital. I was back out to see him early next morning and three of his brothers were there but they also had no money. I stressed the seriousness of the case and ask them to raise enough money from some source to pay (the) hospital bill. I was on my way to an O.B. case then and told them I would be back in time to cary him on the early morning train to (the) hospital. Well I did not get back until after nine o'clock that night.

"The three brothers had left soon after I did that morning and had not yet returned and I found the appendix had ruptured. I drove in to town, woke Dr. Green* and told him we would have to operate on the case at once or he would die. All the time we were folding the operating table Dr. Green was telling me what the probable outcome would be in this case so far as what people would say . . . if we operate and he dies a great many are going to say the new doctor took to much of a chance. . . . Well we arrived back just as it was coming dalight. We set up our operating table. I started my sterilizer with alcohol going for instruments. We had them build a fire around the wash pot out in the yard. Into this pot we put a half dozen sheets we had brought from our office including a Kelly pad into this we crushed up several bichloride tablets. After giving him a thorough scrubbing bath we started to literaly wrap him up in these wet bichloride sheets. No screens were on the house and a regular swarm of house flies were everywhere. We put some three or four to fighting these flies. We put the patient to sleep and amediately turned this job over to an old farmer with the longest and the hevyist mustash I have ever seen on any human being. We watched him carefully and gauged the ether to where it could be poured on the mask almost constantly. We cut into him and when we ruptured into the puss pocket we found it was a colon bacilous infection and the oder was so terrible until our fly fiters simply deserted us and Dr. Green and I had to do our own fly fighting while we finished up operation (and) put in drainage tubes and dressings on (the) field of operation. Our old farmer anethtist turned pale but stayed on the job until we told him he could remove the mask. He was just ready to pass out by this time and went reeling and stumbling from the room. When we had a large bundle of gauze packed around our drainage tubes and quite a few removable pads fixed to

O. F. Green, M.D, 1905

*Dr. O. F. Green, who practiced at Mayo, Florida (1907-1967) and who was Dr. Anderson's brother-in-law.

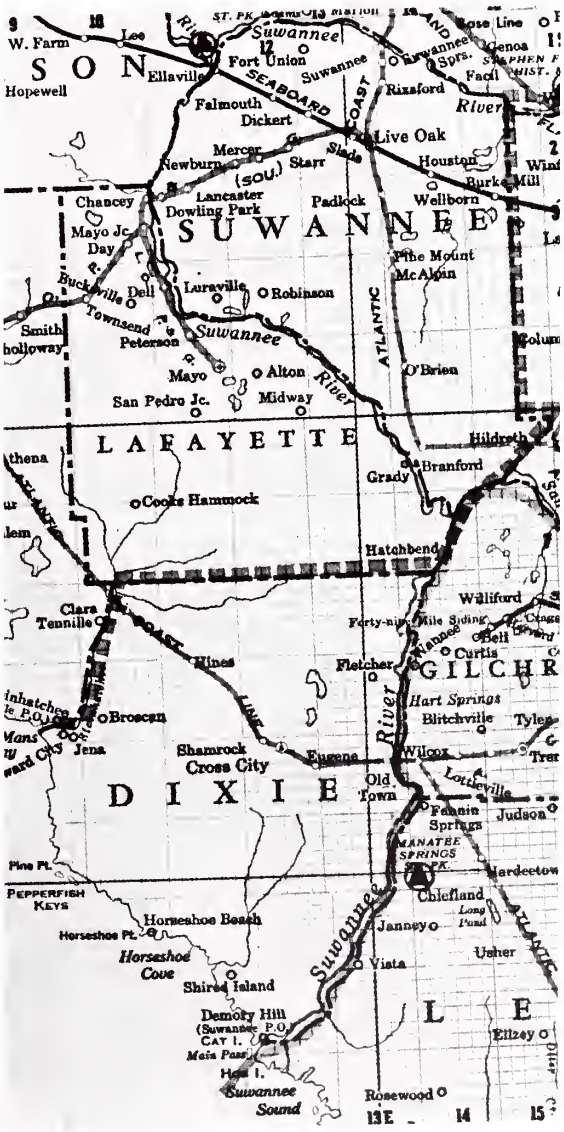
catch the drainage from these tubes, Dr. Green and I also came out to catch the fresh air away from this terable stinch. I can never forget the sight of this old farmer when we came out. He was setting on an old time rail fence fanning himself with his hat. He looked up and said, 'boys when I came out of the house a swarm of buzzards just were missing the top of the house as they flew back and over it.' Strange as it may seem that under these terible unhigenic circumstance this patient made an uneventful recovery."

Thus writes James Martin Anderson, M.D., (1881-1952) of his experiences as a country practitioner at Mayo, Florida, in 1910. Dr. Anderson preferred to avoid "kitchen table surgery" by transporting patients to Gainesville or Jacksonville but often there were no funds for transportation or he was called so late that time did not permit transportation. He tells us: ". . . I again want to pay my respects to my associate, Dr. O. F. Green. In the field of old ruff surgery, which we were forced into doing out there a hundred and twenty-five miles the nearest efficient hospital, the only way we could get patients to (the) hospital was to put them in a wagon, hall them in to the nearest R.R. station, put them in (a) baggage car, go with them to Live Oak where we would change them to another train for Jacksonville, where we could call (an) ambulance for transfer to (a) hospital."

When Dr. Anderson began practice automobiles had not reached the rural areas of Florida in any number. Twenty-nine years old and fresh out of medical school he recalls: "When I had purchased two ponies and a buggy I found I was seven hundred more dollars in debt and had not yet made a dollar out of my practice." During the next two years the buggy and pair covered many miles in Lafayette and Suwannee counties. "During the last six months of our horse and buggy days our practice had increased to where we were forced to systemize our practice. We had very little office practice but about sun up each morning I would hitch Sid and Minie* to my buggy and start out on my rounds. Usually I would cross the Suwannee River at Luriville (Luraville) and spend a good portion of the day making calls in Suwannee County. My poneys had a fire disposition and if you did not pet that disposition you had trouble with them the whole day long. But if you would pet that disposition during the first hour, in which they would clip off ten miles, they would settle down to a little jig of a trot which they would keep up for the balance of the day.

"When my calls were up the river, I could usually make them by from twelve to one o'clock. Then I would drive down to what was called Peacocks Ferry, get John Peacock to ferry me across the river, get my lunch at Dell Station, and spend the rest of the afternoon making calls on the Lafayette side and arrive back in Mayo late in (the) afternoon. I always carried with me a light feeding of sweat food for (the) ponnies, which I would give them while I was eating my lunch. . . . While I was buisy working up and

*Usually a buggy was driven with a single pony, but Dr. Anderson preferred a pair as they made the buggy go faster.



Suwannee, Lafayette and Dixie counties

down the river from the Luriville bridge, Dr. Green was just as buisy working the country practice from Mayo to Branford. It did no good for people to show a prefference for either doctor during the last six months of our horse and buggy days. We were both compelled to stick to our regular roughts.

"Well along toward the close of 1912 Dr. Green, Dr. C. A. O'Quinn and myself all bought cars. Dr. Green a Ford, Dr. O'Quinn a Hupmobile and I a Maxwell Mascot Roadster. This car had a twenty gallon fuel tank on (the) back. It was almost solid aluminum throughout and as far as looks were conserned it would be considered modern even today. It had an old Rema magneto and as were all the cars in that day had dry cell batries for us to crank up our cars on. All cars also had the old carbide lamps on them. These soon began to give us trouble on account of the ruff unpaved roads we had to drive over so it was only a short time before the Prestolight tank were fasten to the run boards of our cars. . . . We met with other dificulties in the use of our cars . . . many of the roads that had been in use for years had stumps in them that our cars would not pass over. This was especially true of my car. The front axil was about one inch lower than the other doctors cars and it was equipped with a fly wheel in front that came down to the level of the axil. I soon found myself knocking up stumps either with the axil of the car or what was worse still that old fly wheel would catch them and break the fly wheel—this forced me to keep and extry fly wheel on hand at all times.

"Another handicap was that none of the country (roads) had bridges on them where high water did not interfere with wagon travel in high water time. This forced us to carry along with us a couple of yards of oil cloth that we would spread over our radiators and let it float back under the ingines in our cars and by putting our ingines in low gear taking off our fan belts we could cross narrow channels of water before our ingines would drown out. . . . Still another handicap, we did not have any garage men in that day and were dependent on our village blacksmith to straighten out our bent axils and repair work in general. As a consequence we doctors became quite adept at repairing our own cars. I remember my car had two inervations that were not in the other cars at the time. One was it had a ring gear that was bolted to the shaft with screw bolts and cotter pins and did not have to be put on with hot bolts as ribts. Another was the tank was arranged to hold back two galons of gass until you turned on a specil forcep and I never ran out of gass. Another was my car would run on kerosene after the engine got hot and I never had to come in to town to get gass until I had finished my calls as I could always find a farmer with at least a gallon of kerosene.

"Another trouble we had in those early days the rural population were extremely predjudiced against the use of cars because they some times frightened horses and mules and those who were driving teams that were not frightened gave us more trouble than those that were, for they would take the center of the road and refuse to give us the courtisy that they would grant other vehicles of giving half of the road. . . . One old fellow was extremely predjudiced and seemed to realy enjoy delaying moterist. He came into town and left a call for me to come to see his sick son as soon as I came in and pretty soon I came in and was informed of the call. So I cranked up my car and started out to make the call. It was on the only road in the county at the time that an attempt had been made to harden the surface. It was a nine foot sand clay road and we would have considerable trouble passing cars even where they would devide the road with you. Well about four miles from town I caught up with this old fellow and blew my horn. He evidently did not expect me so soon and he never even looked back and stayed in (the) center of (the) road. I threw my car in low geer and drove along behind the old man for about a quarter of a mile until I came to a house where the road widened to where I could turn around and that was just what I did and headed back to town. The old man did turn his gaze enough to see it was my car and turned his horse and buggy around and drove furiously back behind me. But by the time he got back to town I was out on another call. He was furiously mad and unloaden all his predjudic against the moter cars to Mr. Ware*. . . . The old man said, 'I just don't like the way all automobile drivers drive up behind you and blow their horns as if we farmers have no right to the road at all. . . .' The old fellow had to wait until nine o'clock that night to see me. He was still just a little riled up and said to me, 'you could have driven around me just as easy as you could have turned your car around.' I said, 'yes and you still would have retained your prejudice and continued to delay our calls. . . .' Well this epesode was prety well advertised up toward Bowling Park across the

*Mr. Raymond Ware, pharmacist and owner of the Ware Drug Store in Mayo.

river from Luriville and I found no more trouble from that section. . ."

The rural physician of that day was expected to handle all medical problems and, indeed, Dr. Anderson was an avid reader of medical journals, frequently attended the Alachua County Medical Society and the Florida Medical Association meetings, and from time to time attended postgraduate courses in New York and other cities. Soon after coming to Mayo he had a minor syphilis epidemic, ten cases all at once. He tells us about the treatments then in vogue. "So I began the only treatment known at that time, mucury internaly, externaly and eternaly and in order to clear up symptoms more quickly saturated solution of potasium iodide in increasing doses starting on five drops, increasing one drop to the dose each day to the point of tolerance which would be manifested by sneezing and symptoms of a bad cold, then they were to drop back to five drops and start the increase all over. . . . These ten cases had been under energetic treatment for about six months when the 606 treatment came out. . . . I wrote Dr. Al Fowler,* our GU man when I was in college and he replied he was using it and if I would come to Atlanta he would be glad to aid me in securing a supply and the instruments for its use and demonstrate the proceedure while I was there . . . the men shelled out two hundred dollars to pay my expenses and buy equipment . . . (the equipment was) a doubled barel affair with two glass tubes and petcocks on them. You attached a ruber hose and needle, put 500 cc of normal salt in one barrel and desolve 45 grains of Arsphenamine in 500 cc of water in the other barrel, (and) hang this up. Your needle was fit on to a little glass bulb and after you had filled the ruber hose with normal salt solution and letting (the) patient ly down cord the arm, puncture the vein and if blood came back in your little bulb, you would first turn on your normal salt for a few seconds and then if it was going O.K., you turned on your Arsphenamine solution. It took just about one hour to run this thousand cc of fluid into the vein and our reactions were terible. The patient would alternately sweat and freeze while we were giving it and then when they would get home have a chill, perhaps a high fevor, (and) some become very much nauseated and vomit, but all ten

*Dr. A. L. Fowler, Professor of Genitourinary Surgery and Venereal Diseases, Atlanta College of Physicians and Surgeons.

Ware Drugstore, Mayo, 1912
l. to r.: Grandfather Ware, Raymond Ware, O. F. Green, M.D. and J. M. Anderson, M.D.

came through. . . This was supposed to be a cure in that day but Dr. Fowler recommended that I give each of them a hip shot of murcury once a week for a six weeks."

Perhaps the greatest scourge of Florida in that day was malaria and a severe outbreak of this disease played an important part in Dr. Anderson moving to Cross City where he went into practice with Dr. T. C. Jones, January 1, 1929. "First let me state the condition I found Dixie County in January 1st, 1929. I received a telegram from my good friend, Dr. T. C. Jones, that Dixie County was in the grip of the worst epidemic of malaria it had ever known and ask me to come over and help him out. I don't think I would be exagerating at all to say that at least 90% of (the) population of the county had an active case of malaria when I arrived. As this was in the midst of the winter months they had evidently been carried over from a late warm autum of 1928. When I say these people had malaria I don't mean the ordinary chill and fever type, but the esteivoautumnal type that was just as malignant as is found in the jungles of Africa or South America. . . Dr. Jones and myself treated seventeen cases of the so-called hemorhagic type between January and August of that year. We had had twelve cases of a malignant type, toxic in nature, that were much more malignant than those accompanied with hemorrhage. . . . Dr. Jones and I had not had a single death up to August 1st, 1929 . . . then there came an early frost in September of that year and three cases came down with this malignant type and all three died very promptly."

James M. Anderson, M.D., 1948

Dr. Jones who had had experience in treating malignant malaria in Mexico prior to coming to Florida believed in a vigorous treatment in such cases if they didn't have "a weak or sinking pults." Dr. Anderson describes the first such case he saw with Dr. Jones. ". . . we were called to . . . an old charity case some twenty miles from town. A doctor from Carbu (Carbur) had seen him twice and perhaps had they goten any of the medicine in him, might have done him some good but he was delirious and would spit out any medicine or water they put in his mouth. Abdomen enormously distended, pults full and bounding, temperature 104, constantly rolling from side to side. . . I said, 'Doctor, I have just had six cases like (this) in my practice and although I called consultation, took specimens of blood from each and never did find out what the trouble was, but they all died and (I) think that is what he is going to do.' He said, 'I differ with you there, this case will stand some heroic treatment and that is just what we are going to give him.' He ask his wife if she had any hot water . . . and then he ask about soda. She brought out a pound of Arm and hamer brand. He put about ¼ (of) the soda into a gallon of hot water and four of us held while he passed a stomach tube into his stomach. He began to pour this soda mixture into his stomach. At first the fluid contents of his stomach was so strongly acid that it bubled back into the funnel of the stomach tube. He pumped this out which was almost black in color. He filled the stomach again and again until he had used the whole gallon of soda water in washing the stomach. Then he put twenty grains of calomel into the tube and washed it into his stomach with two ounces of Fleets Phosphate of Soda and amediately took the stomach tube out. He then called for another gallon of warm water. He desolved another four tablespoonsful of the soda in this gallon of water and we put him on a Kelley pad and he gradualy worked a five foot rectal tube into his colon and he used another gallon (of) warm soda water washing out his bowels. Great quantities of gass and fecal mater came away also and when he had finished it almost filled a ten quart slop jar and his belly was perfectly flat. He then said to me, 'take whatever blood specimens you want to examine.' He then had them turn him over and injected thirty grains of quinine in each hip, then corded

his arm and gave him seven and a half grains in his veins watching his pupils while he slowly pushed this into his veins. The results were magical. (When) we left this case, his temperature was almost normal. His pults were regular but had lost their sledge hammer blows and he had appearently drifted into a normal sleep. . .

"Well it was my turn to go to The Wilson Cypress Co's camp the next day and when I came in sight of this place I saw all the bedding of his house out on the fense and of course I thought this is a sign the fellow had passed out during the night. I had not been in camp but a few minutes until a boy came in the office and said, 'Pa wants you to come by on your way back and see him.' You can imagine my surprise when I arrived and found the old fellow sitting up in a chair smoking his pipe. I found he was not delirious as his wife thought he was but the events of what had gone on for the past four days were simply a blank to him and what he was fussing with his wife about was that she would not give him anything to eat but was insisting he only take the sweetened bunch of slop as he expressed it. . . The twenty grains of calomel and the phosphate of soda had purged him and as a consequense he was somewhat dehidrated. His temperature was still 100 F. So I hung up a bottle of a pint of 10% glucose and let it run into his vein. I came back by some two hours later and gave him fifteen grains more quinine interveinously although he was still somewhat deaf from the enormus dose he had the day before."

Dr. Anderson and his colleagues frequently examined blood smears for malaria parasites and he recognized "that the doctors are still almost unanumus in their opinion that a case that does not show parasites is not malaria," yet he and his colleagues obtained salutary results in certain cases with quinine even though the smears were negative. "We pursuaded a deligation from the Rockefellow Foundation to visit us from their headquarters located at Madison, Fla. They clinically examined our school children and found 100 in Dixie High School with clinical and physical signs of malaria. They took specimens from these one hundred making several smeers from each case. . . I givem credit for finding the largest percentage of paricytes that had ever been found in this locality but it only amounted to 23 out of the one hundred. . . Ten of those reported negative were out of school with fever before we received the report . . . not one of those reported positive had had any fever in this time. We began treatment of the hundred that had been diagnosed as having malaria and managed to keep them all in school for the rest of (the) term." Anderson goes on to express his opinion that negative smears in cases that clinically seemed like malaria were possibly due to the widespread use of "chill tonics" such as the popular 666 which contained small doses of quinine and could be bought over-the-counter in the country drugstore. The small amount of quinine suppressed the malaria parasites but did not eradicate them.

Not only did Anderson and his colleagues treat disease but they also addressed themselves to preventive measures. For example, as relates to malaria, when he went to Mayo in 1910 screened houses were uncommon but, he tells us: "Dr. Green and I were still preaching that it was cheaper to screen houses and prevent malaria than it was to pay the doctors and buy the medicine to treat it. But people were slow to become convinced that malaria was caused exclusively by the mosquito that had regular feeding habits that made it comparatively easy to prevent. . . Yet when our horse and buggy days were drawing to a close people were becoming conscious of the comfort of living in screened houses away from the mosquito and house fly. Added to this comfort was the demonstration that wherever someone screened their places health improved. . . Dr. Green and I would warn people against renting any house that was not screened and had a sanitary toilet in it."

When he moved to Cross City, as we have seen, it was in the throes of a malaria epidemic. Anderson studied the problem of flooding and ground water in the area and with the help of a county commissioner set about to drain the swampy areas. He also encouraged the covering of stagnant ponds with mixtures of gasoline and old motor oil. This was of course ten years before the introduction of DDT.

Another great scourge of Florida, indeed of the South, was hookworm. Hookworm had been recognized in Florida as early as 1903[1] but it was in 1908 that serious efforts to eradicate this disease were launched. The Rockefeller Sanitary Commission spent five years and $1 million in the southern states finding out that clinics alone would not solve this problem.[2] They and the State Board of Health surveyed Florida and found the incidence of hookworm in the school students of Taylor County to be 60% and 83% in Escambia County. When Anderson began his practice

at Mayo the drive to eradicate hookworm was on and he offered his services. "During the first few weeks I was of very little help to Dr. Green and had plenty of time to seek out children that I believed had hookworms and urge parents to bring me specimens to the office. I would where posible insist that the parent that brought the specimen stay with me until I had located the eggs. First with the low power on (the) microscope and let them have a look at the numerous eggs we found. Then I would locate a single egg and turn on the second power of (the) microscope and with good light this would show the shell of (the) egg and interior as well. . . . Convincing the parents was comparatively easy but the treatment in those days realy did have its hazards. Thymol and Betanapthol were the only two remidies known at that time. You had to starve them both before and after treatment. We would often run into fierce opposition from parents on this account. I remember one quite amusing incident along this line. I had discovered five children in one family that had the worms. I prescribed the treatment and so far as I know the mother gave it religiously as directed and admitted each child past quite a quantity of worms, but when she sent in another specimen the children still had worms. The mother weighed about 250 lbs. . . when I told her the children would have to take another treatment to get rid of worms, she rebelled. Giving as her reason that she simply could not eat on days that she starved the children and she was just not going to undergo another day of starvation like she did when she gave them the first treatment. . ."

About his efforts as county health officer in Dixie County he tells us: "The State Board (of Health) and WPA (Works Progress Administration, an agency of the New Deal), furnished a nurse and a secretary. State Board of Health also furnished free hookworm medicine. Twice a week we would have (the) school gather forty of the children that had shown definite signs of being ill. Rockefellow survey had shown 87% of children of school age had hookworms and we had a list of their names, so but very few went through the clinic without being given three treatments to be given one week apart."

Anderson's efforts at preventive medicine as applied to the hookworm problem were apparently not so successful. "When we would cure a case of hookworm disease and instruct mothers to make their children wear shoes until the dew or rain had dried off the grass, not one mother out of four would see they obeyed these rules. So three out of every four children that we cured of this disease would have it again within a year after we had cured them." Incidentally he tells us that the State Board of Health as an incentive paid the private practitioner ". . . a dollar and a half for each case we would treat until it was cured. We were finding it dificult to get patients to submit to enough treatments to accomplish a cure but we were able to draw some fifty dollars per month from this source, which of course nothing like paid us for our work but was some help."

About smallpox he tells us: "Occasionally a case of Small pox would brake out and the Town Council would get all steamed up because we would not quarantine everyone in a city block of where the case was. I remember on one occasion when this happened Dr. Green rolled up every member of the councils sleeves and not one could exhibit a scar to prove he had been vaccinated so we insisted on each of them being vaccinated then and there.

"I finally told them the patient and the nurse were already quarenteened and the other two known exposiers had been asked to stay in their houses until their vaccination took. Now I am not telling you that this eliminates all danger for this case. This fellow walked the streets of Mayo for two days with a high fever before he broke out. Dr. Green and I were very buisy so I wired the State Board of Health to send a man to help us out with the vaccination. Well for the first time in the history of Mayo pretty well all the citizens of Mayo were vaccinated against smallpox. The irony of the situation was that there (was) not a single case of smallpox in Lafayette County from this case but appearently Dr. Green's first cousin had brought three of his children over to put them in school and he must have contacted the disease while in town. These three were vaccinated during our crusade but as he was across the river in Suwannee Co. and the way we had to go with our cars fifteen miles from Mayo and before we made the diagnosis of his case his wife and two other children also had the disease with wide range of exposiers in that county. Dr. Green and I were kept buisy vaccinating these exposiers for some time. Then our troubles sure enough began everyone expected us to treat all the sore arms and would become very indignant that treatment did very little good.

"However our trouble was small to compare with the trouble they were having over in Taylor

County at the same time. A doctor over there in Perry was the leader of the anti-vaccination society. I don't think the doctors over there had any regrets when he himself developed the disease that scared his face up pretty well. Dr. Green and I often discussed the fact that we received a great deal more cussing about the free work we rendered than we did over the work we charged for. Never-the-less incouraged by Joseph Y. Porter, State Health Officer, we continued our welfare program. He would often write us a two-page letter complimenting our unselfish program for the citizens."

Dr. James Martin Anderson, born November 14, 1881, was the 12th of 13 children of Robert Sidney and Frances Riley Anderson. His parents farmed land between Greenwood and Abbeville, South Carolina. Seeking a healthier climate his family moved to a farm near the present town of Mena, Arkansas in 1885. His parents were frugal, industrious, resourceful and education-minded people. Thus while he attended a typical one-room grammar school and later the Mena High School, at home his mother supplemented his "book larnin." His father, who had served four years in the army of the Confederacy, taught the boys farming, cattle raising, hunting and the manly art of self-defense. Among his social attainments was proficiency in dancing. He speaks with pride of being the only one in his school who could execute the rabbit dance on a six inch board. Later he became adept at the waltz, schottisch, and the two-step.

Following the death of his father in 1894 and his mother in 1898, he, two sisters and a brother moved to Wade, Florida to live with a bachelor uncle, Frederick Riley. The boys went to work mining phosphate with a company near Ocala which was partially owned by another uncle, John Riley. When barely 18 years old Anderson was foreman of a pit crew and sported a heavy red moustache to match his full head of red hair. About three years later he went with the Highsprings Phosphate Company as plant manager but soon economic problems made this job untenable. He yielded to the importuning of his brother and an uncle to join them in a mercantile business and became manager of the Riley and Anderson General Store at Mayo. Here he met, courted and finally on January 29, 1905, married Annie Viola Sears. After a short honeymoon he took his bride to live at the Riley and Anderson store at Wade, Florida. He soon found that storekeeping in a small town was a rough business and not al-

James M. Anderson married Annie Viola Sears, 1905

together to his liking. ". . . I realized at the time that this was no place to cary a bride and expect her to be satisfied. Business was good but it was a place that had to be controlled by what we called pick handle law. Each merchant would have a pick or ax handle close at hand and if the men . . . got to boistrus we would simply quiet them down by use of (the) pick handle."

Also about a year later their first-born child became seriously ill and ultimately died. Struck by what he considered the ignorance of the physicians available in that rural area, he determined to study medicine. With the aid of a schoolteacher sister he prepared himself, passed an examination and was accepted by the Atlanta College of Physicians and Surgeons.* Here he spent the years 1906 to 1910 living frugally and studying long hours. His wife helped to meet expenses and they took in as a boarder their friend, Eugene G. Peek, who later had a distinguished career as a practitioner in Ocala, an active member of the Florida Medical Association and

*This medical school had its beginnings in 1854 and subsequently became the Emory University School of Medicine. In Anderson's day applicants were required to have a grammar school education and "two years of successful attendance at a recognized preparatory school or high school." The course of study was four years of thirty-two weeks each. The school boasted of the most modern laboratories in: Anatomy, Physiology, Chemistry, Histology, Bacteriology, Pathology and Pharmacology in addition to a large dispensary and the Grady Hospital to provide a wealth of clinical material.[3]

its President (1943). At the end of these medical school years he had an M.D. degree, a $700 debt and his first son, James Loomis Anderson, M.D. (1907-1973). Soon after graduation he settled at Mayo and entered a partnership with his brother-in-law, Dr. O. F. Green. Although he tells us the office practice was quite small, he rapidly developed a widespread country practice in Lafayette and Suwannee counties. Initially he made his all-day rounds in a buggy and later in automobiles. Skill in driving an automobile seems not to have been one of his strong points. To quote from an article in the Dixie County Advocate: ". . . Dr. Anderson failed to conquer the feat of driving an automobile. Everyone knew his automobile and would always give him a wide berth when they saw him coming. His ability to hit the corner of the Atlantic Coast Line Depot prompted the A.C.L. officials to place a steel rail at the corner of the building. After a solid connection with the steel post, he discovered that he could make a sharper turn."[4]

His second daughter, Margaret, was born in 1915 and a second son, Malcolm, in 1925. About 1925 he moved to Hendry County as physician to the Standard Lumber Company mill at Sears and after that mill closed he lived for a few months at Lake Wales.

Finally, in late 1928 an old friend, Dr. T. C. Jones (-1932), who was the only physician at Cross City, asked him to come to Cross City to help with "the worst epidemic of Malaria Dixie County had ever had." He arrived there on January 1, 1929, and practiced there continuously (for many years the only physician) until his final illness forced his retirement a scant month before his death.

One of his oft-repeated sayings was: "Any community should be a better place for your having lived there." That he sincerely believed this he demonstrated by: serving as Dixie County Health Officer for many years beginning in 1929; organizing a County Board of Health; organizing drives to rid the county of infectious diseases; teaching an adult Sunday school class regularly for more than 20 years; and serving on the Cross City Council beginning in 1939 and for some years thereafter. For a period of this time he was president of the council and mayor of Cross City.

The events that led to his election to the city council he describes thus: "Our town was in a mess. Hogs and cattle roamed our streets at will.

At the dedication of the James Anderson Elementary School, Cross City, December 15, 1968
l. to r.: Malcolm Anderson, Margaret A. Moorer and James L. Anderson, M.D.

We had no waterworks or fire protection. Our drinking water came from shallow wells and 90% of toilets were of the out door type and in wet times the water level was almost to the top of (the) ground in the higher places and in low places would flood the town to where many would have to move out. I had gone before the council (ie. as county health officer) several times and ask them to make application through the CWA (Civil Works Administration, an agency of the New Deal) for self liquodating time certificates. They tried four times unsuccessfully to put this proposition over . . . Finally we had what I had been afraid of so long, an epedemic of typhoid fever. There were twenty cases in two weeks. We traced the infection to two wells in the heart of the town but an examination of all the water supply from the various wells in town showed 51% of the wells had colan bacilla in the water." Four of the 20 cases died and the remaining 16 had prolonged illnesses, he tells us.

Stung by this catastrophe he called the Senator representing them in Washington to inquire why they couldn't get federal help for installation of a waterworks. He learned that Cross City was deeply in debt and the practices of the incumbent council made it impossible for the Senator to get the help he requested. At the urging of his friends and his own conscience, and with the agreement of two honest and successful businessmen to run with him, the three successfully ran and took office in January, 1939.

As he had been informed the new council found the city deeply in debt and with suits filed against it. They also discovered a grossly inadequate tax base and many taxpayers that were in arrears several years. They set to work collecting back taxes, effecting economies, levying new taxes, drawing up a new city charter which would permit a wider tax base and paying off the old debts. Over the next several years the needed federal help and bond issues were obtained and the waterworks built, the town streets were paved and lighted, fire mains and hydrants were installed and the cattle were gotten off the streets. Although he retired from the council about 1945, he continued to lend vigorous support to progressive movements for Cross City. Thus when the town had outgrown the waterworks built largely through his efforts, he spearheaded a drive to raise money to connect the city's mains with the waterworks at the nearby Army airfield which the Federal government offered on a lease basis.

In 1949 he began having increasing weakness, fatigue and dyspnea due to arteriosclerotic heart disease with congestive heart failure. However he continued an increasingly limited practice finally writing prescriptions from his sick bed until a month before he died. In early September, 1952, his physician-son took him to Miami to be hospitalized. The last illness finally came to an end at Mercy Hospital in Miami on October 5, 1952. It is said that near the end he assured his son and the doctors in attendance that they had done all that anyone could do and his time had come. He then requested that they remove the oxygen and support measures and so quietly ended a life dedicated to service of his fellow man.

Acknowledgements

The editor wishes to express his appreciation to the late Dr. James L. Anderson, Mrs. Eunice P. Anderson and Mr. and Mrs. Sam H. Moorer, who supplied the manuscripts, illustrations and the biographical information that made this article possible. He would also like to thank Miss Nena Perry, Reference Librarian of the A. W. Calhoun Medical Library, Emory University School of Medicine, for the loan of the Catalogue of the Atlanta College of Physicians and Surgeons.—WILLIAM M. STRAIGHT, M.D., HISTORICAL EDITOR, JFMA.

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3. Atlanta College of Physicians and Surgeons Catalogue, Published by the College, July, 1910, pp. 32-36 and 42.
4. Dixie County Advocate, New Elementary School Named in Honor of Dr. J. M. Anderson, June 14, 1968, p. 1.

Friendships are fragile things, and require as much care in handling as any other fragile and precious thing.

—Randolph Bourne

Volusia County Medical Society History

P. A. Drohomer, M.D.

The early history of the Volusia County Medical Society is represented only by the names of individual physicians but they give it a background and a flavor. Recorded proceedings of the Society's deliberations in those years do not exist. What happened to them and to its organizational makeup prior to January 13, 1925 has not been determined.

The Society existed in 1902 according to a report in Transactions of the Florida Medical Association for the years 1902-1906. Specific information is lacking. The names of members are given as Drs. E. C. Atwood, president, F. L. Meagley, secretary, and William Seelye, all of Daytona; Drs. G. A. Davis and George MacDiarmed, DeLand; Dr. J. H. Cox, New Smyrna Beach; Dr. H. K. Duboise, Fort Orange; Dr. J. H. Esch, Goodall, and Dr. George Keer, Pierson.

Volusia had become a county officially in 1854 and at that time three small centers of population existed: Daytona Beach on the Atlantic Coast, DeLand at the western limit of the county, and New Smyrna Beach, a settlement at the southern end.

Dr. E. C. Atwood, first president of Volusia County Medical Society.

The first physician to practice in Daytona Beach was Dr. George W. Wallace who was born in Savannah in 1835. He settled in the area in 1870 and served on the first council after the village was incorporated in 1876 and as mayor for ten years, 1877-1887. There is evidence that he lived in what is now Ormond Beach in 1874. Other physicians soon to begin practicing in the county included a Dr. Malette, Dr. George A. David and Dr. H. Munson in DeLand and Dr. J. B. Bouchelle in New Smyrna Beach.

Dr. Malette opened an office in 1881 and Dr. David in 1890, the year he received the M.D. degree from Atlanta Medical College. He was born at Fayetteville, Ga., in 1858. Dr. Bouchelle also received academic training at the Atlanta Medical College and graduated the year after Dr. David. He began practice in 1893. Dr. Munson was born in Wisconsin in 1851 and was graduated from Bennett Medical College in Chicago in 1873. He studied abroad and came into contact with Dr. Konrad Roentgen. He moved to DeLand in 1895 and was the first physician to use x-ray in Volusia County. He continued practicing until 1920.

The president of the Volusia County Medical Society in 1902, Dr. Edward Carlton Atwood, was born on a farm near Pelham, N. H., on September 24, 1848 and attended Westford Academy and Dartmouth College. For a time he worked as a surveyor in Vermont and Maine and married Caroline Shaw. Because of his wife's health he was advised to seek a climate as far south as he could. He finally came to DeLand but since two doctors already were in that area, he was advised to move 20 miles east to a small coastal settlement known as Daytona. Here, he established a pharmacy, concocted most of his medications, made horse and buggy house calls and often was paid for his services with produce and small articles of value. A daughter, Evelyn, became a concert pianist. Now 96 years old, she lives in Daytona Beach.

Dr. Josie Rogers who still lives in Daytona Beach received the M.D. degree from Alfred University and School of Medicine in Chicago in 1907, five years after Dr. Atwood's term as president

of the Society. Her parents had moved to the area in 1873 and she was born three years later. She recalls having attended high school in Ocala.

Dr. W. C. Chowning began practicing in New Smyrna in 1906. He had been graduated from the University of Maryland School of Medicine in 1904.

Hospital Facilities

Some early physicians were extremely resourceful performing difficult surgical procedures on kitchen tables under kerosene lamps. These efforts represent scientific landmarks but are the exceptions. The difficult cases whether medical or surgical required the treatment available in a hospital. By 1918 Daytona had two small ones: Dr. Klock's Hospital and Dr. Bohannon's Hospital. It was not until 1926 that the community's conscience was stirred enough to establish the well-equipped and handsome structure known as the Halifax District Hospital. It opened in 1929 and almost simultaneously the Western Volusia Hospital was erected in DeLand.

More Recent Times

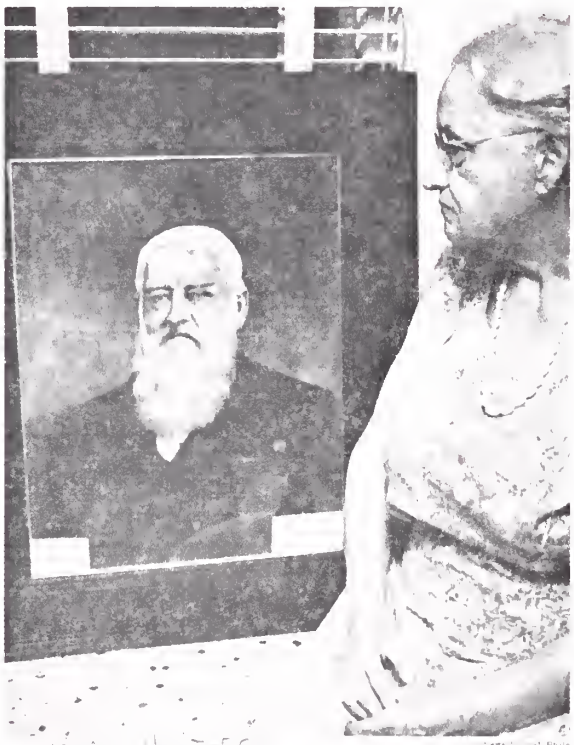
The Volusia County Medical Society had 35 members in 1925; Dr. H. S. Woodbery was president and Dr. L. W. Glatzau secretary and treasurer. Meetings were held in various doctors' offices, at an appointed place in DeLand, and rotated between New Smyrna and Daytona Beach. At that time roads were laid with flat bricks, were narrow, twisting and winding around sloughs, swamps and heavily timbered areas making night driving hazardous. By 1929 there were 40 physicians in the county society.

Dr. Hugh West began practice in DeLand in 1925 and became one of the "firsts." He performed the first thyroidectomy under local anesthesia in the county. He was the first surgeon to use spinal anesthesia for abdominal surgery. After studying under Dr. Smith-Peterson at Harvard, he was the first in the county to use the Smith-Peterson nail in repositioning a hip. Dr. West was graduated from Emory University School of Medicine in 1923. He became a Fellow of the American College of Surgeons in 1935. He retired recently but is still an avid angler and hunter and recalls the time when fish and game were available almost at his doorstep.

Dr. J. Ralston Wells admitted the first patient to the Halifax District Hospital in 1929. He was the first Fellow of the American College of Surgeons in the Daytona Beach area, and when the American Board of Surgery came into being, he was made a Diplomate. Dr. Wells, born in 1889, graduated from the University of Pennsylvania School of Medicine in 1912. He served a residency in surgery at Presbyterian Hospital in Philadelphia and when World War I broke out joined the French army as a surgeon. He joined the U. S. Army Medical Corps upon this country's entry into the conflict in 1917. At the end of the war he returned to Philadelphia to resume the practice of surgery, but came to Daytona in 1925.

Other surgeons in the area included Drs. Klock, Fogarty and Bohannon, Joseph Rutter, C. W. Davis, J. B. Davis and the Howe Brothers, and Dr. West in DeLand. Dr. Maximillian Stern, who came to Daytona on a semiretired basis, in association with Dr. A. M. McCarthy developed the Sterm-McCarthy resectoscope which revolutionized prostatic surgery.

Specialization began with Dr. R. L. Miller, an otolaryngologist, who began practice in Daytona in 1926. Up to this time most members had engaged in general practice. He became secretary-treasurer of the Society the next year, serving in this capacity for many years except a term as president in 1955.



FIRST DAYTONA BEACH DOCTOR

FOR CORRECTION SEE 3-768

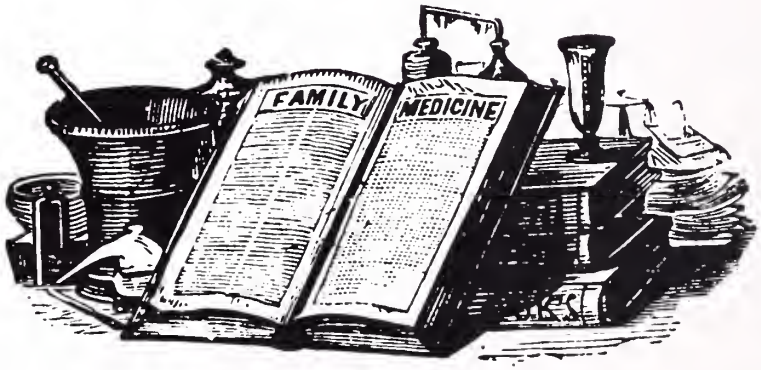
Dr. Ludo von Mysenbug in 1936 was the first board certified pediatrician and Dr. Eric Lenholt in 1937 the first board certified ophthalmologist. Dr. C. Robert DeArmas, a radiologist, assumed responsibility for the x-ray department at Halifax District Hospital in 1947. Until that time it had been conducted on a contract basis by technicians Donald B. Campbell and Duncan Dale.

With outbreak of World War II in 1941 Drs. Drohomer, Jennings, Jones, Lenholt, Myres, Reeser, Rutter, Seltzer, Shaw, Silsby, Tribble, Vallotton, Wells, West and Whitney from the Society became active members of the Armed Forces. The following year the Volusia County Health Unit was established, headed by Dr. Robert H. Higgins assisted by two nurses.

During the postwar period the Society's membership increased rapidly. The newcomers showed meticulous adherence to excellence in practice and humane consideration toward patients regardless of their station in life. They took their places in the medical community, some as leaders among their peers, others became interested in government and showed by their actions that integrity and politics are compatible. An Academy of Medicine was founded which has brought outstanding scholars from all over the United States and Canada who have presented excellent seminars at times lasting as long as a week.

As of November 1, 1973 the Society had 188 members. One or two are being added each month.

▶ Dr. Drohomer, 1224 South Peninsula, Daytona Beach 32018.



Things change.

Marion County Medical Society Its History and Development

Mrs. Robert E. Thompson, Mrs. Henry L. Harrell and Mrs. T. Hartley Davis

Marion County, named for General Francis Marion, "The Swamp Fox" of Revolutionary War fame, was formed in 1844 from portions of Alachua, Hillsborough and Mosquito (Orange) Counties. The county seat became Ocala, a name derived from the Indian "Ocali" believed to mean "Big Hammock" or high fertile land. To new settlers, many from South Carolina, the town appeared to be correctly named. Some had come who suffered from tuberculosis expecting to benefit from the high and dry climate.

The first mention of the Marion County Medical Society was discovered in the files of a Ocala newspaper dated 1884. This is the account: "A group of physicians met at the Ocala House, G. T. Maxwell, S. W. Moody, C. C. Harris, R. B. Fakes, R. D. Thompson, A. Griffith, Dr. Knight, Dr. Hill and J. E. Stubbert for the purpose of organizing a Medical Society for Marion County. Letters of regret were received for Drs. Ferguson and Ellis of Citra and Dr. Smith of Anthony, all of whom expressed their intention to be present at the next meeting. A temporary organization was elected with Dr. Maxwell, President, Dr. Stubbert, Sec'y. and Drs. Norris, Knight and Griffith were appointed a committee of constitution and by-laws to report at an adjourned meeting at the courthouse Jan. 20, 1885."

Dr. George Troup Maxwell is listed by Polks' Medical and Surgical Directory as having practiced in Ocala; however, this fact is missing from the biographical account in R. French Stones' biography of "Eminent American Physicians and Surgeons." He did live and practice in Ocala because the old files mention him frequently. Dr. Maxwell was born in Georgia, practiced in Tallahassee, and was appointed Surgeon to the Marine Hospital at Key West. He moved to Savannah in 1860 where he served as Professor of Obstetrics and Diseases of Women at Oglethorpe Medical College. In 1861 he entered the Confederate Army. At the end of the war he was elected a delegate from Leon County to the convention called by President Johnson for the purpose of "remodeling the Constitution and reorganizing the State Government." He moved to New Castle, Delaware, in 1871 and lived there until he moved to Jacksonville. From all accounts Dr. Maxwell was indeed an eminent personality and skillful surgeon and physician as well as a man of dynamic personality. When it was learned he had been exposed to yellow fever and was seen walking about the Ocala streets, many citizens expressed their concern and indignation. Soon after (1888) he returned to Jacksonville.

In 1885 Dr. Thomas P. Gary who came to Ocala in 1857 was elected president of the Society. Dr. Gary was founder of the Marion County Health Board. During the yellow fever epidemic in Jacksonville (1888) he became aware of the danger to the people of Marion County and immediately began work to prevent the disease from becoming widespread. He organized a system of guards, established thorough sanitation for Ocala, and by securing cooperation of the railroads and influential citizens prevented the entrance of "this fearful disease." When the State Board of Health was established in 1888, Dr. Gary had so greatly improved the Marion County Board's system that it surpassed other counties and received commendation as the best in the state.

Dr. Gary was the great-uncle of Dr. William T. Turnley of Ocala who retired from active practice in 1973.

Dr. R. D. Thompson, present at the first meeting of the Society, refers in 1890 to the "Medical Herald" instead of medical journal. In this journal, said Dr. Thompson, the gin cocktail was recommended by Dr. G. T. Maxwell as a "most pleasant summer beverage which closely ap-

The authors are members of the Woman's Auxiliary to the Marion County Medical Society and historians for the Woman's Auxiliary to the Florida Medical Association.

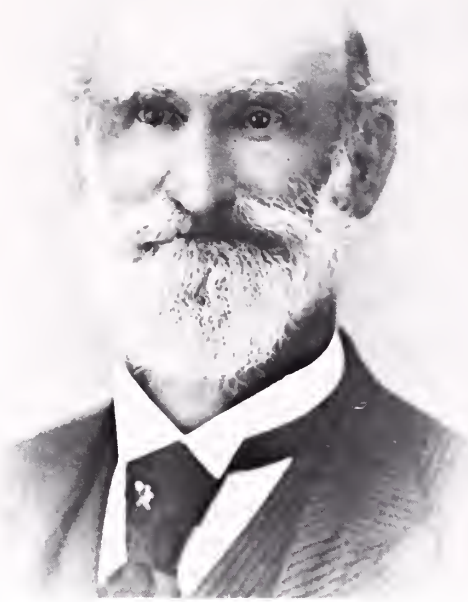


Fig. 1.—Thomas P. Gary, M.D., First President of Marion County Medical Association (1885) and President of the Florida Medical Association (1890-1891).

proaches a specific for Yellow Fever." The quote continues, "the Gin Cocktail is known to have certain gladsome and refreshing qualifications in those milder states of asthenia which follow a days work and which precede a meal. Dr. George Maxwell, however, in addition recommends the Gin Cocktail in treatment of Yellow Fever. His formula is good gin—2 ozs. Compound Tincture of Chickona, 2 oz."

In 1888 the announcement came from Jacksonville that doctors there "still agree to disagree about Yellow Fever treatment." The Atlanta Constitution advised "the way to keep Yellow Fever out of Florida is to buy Cuba and give it a good scrubbing."

Practicing in 1886

These physicians were practicing in Marion County in 1886.

Dr. C. W. Lindner was born in Ohio but spent winters in Florida where he became interested in orange groves and phosphate mining. After the phosphate business took a downward trend he resumed practice. He graduated from Miami School of Medicine in Cincinnati, Ohio. Concerning Dr. J. B. Owens from Anthony Place, the inquiry sent him in 1886 about his graduation got no response. Belleview had two physicians, C. K. Knight and J. F. Pelat. Dr. Knight was present at the Marion County Medical Society's first meeting.

Dr. S. H. Blitch came from Fantville, later Blitchton, in the western section of the county. A member of the State Board of Medical Examiners, he received his diploma in 1878 and served as Surgeon at the State Prison Hospital. W. R. O'Veal practiced in Cotton Plant, population 25; Dr. E. C. Paisley, a graduate of Jefferson Medical College in 1858, in Flemington, population 100, and Dr. A. M. Davy in Fort McCoy.

In the Lake Weir area there were five practicing physicians: L. M. Ayer, J. M. Eagleton, E. C. Hood, J. T. Meyer, and Ruffin Thomson and in Orange Lake and Orange Springs, Drs. Burgin and Ferguson. The latter seemed to have no formal training other than serving as an apprentice to another doctor. Drs. C. C. Harris and James McFadden located in Orange Springs.

In Ocala, population 1,800, were the following physicians: T. P. Gary, W. H. Marian, E. T. Maxwell, George T. Maxwell, S. W. Moody, and James Stubbert. In Moss Bluff, G. A. Dudley was physician for 80 people.

In 1888 the colored "Fraternity of the State" was in session in Jacksonville, Dr. T. P. Floyd of Ocala read a very "creditable paper on dengue." He graduated from Shaws Medical College.

Marion General Hospital

At the close of the 19th century the population of Marion County was 6,000. Although the number of physicians were adequate, no hospital facilities existed until 1898. It had been apparent for many years that hospital services were needed and ways to establish a hospital had been discussed but many obstacles intervened. It was located on the third floor of a building at the corner of Ft. King and Osceola Streets. The other floors were occupied by newspapers: *Baptist Witness* and *The Ocala Evening Star* and *Weekly Star*. The third floor was provided without charge by the Rev. J. C. Porter. On February 5, 1898 most of these had been overcome and the Marion General Hospital was organized by a small group of physicians and local businessmen: Drs. S. P. Eagleton, A. L. Izlar and E. Van Hood, and Mr. C. H. Camphill, Mr. Ben Rheinauer and Mr. C. L. Bittinger, editor of the *Evening Star*. It was soon apparent that more space was needed and financial support was necessary. Public interest was aroused and contributions were received although

it was more or less a private institution. In the struggle and uncertainty many wondered if the hospital could survive financially. Ocala grocers often were told by the physicians to hold them responsible for bills.

The Marion County Hospital Association was formed in 1905. Its Board of Directors included Drs. Hood, Izlar and W. V. Newsom, and Mr. Ben Rheinauer and Mr. T. T. Munroe who was elected the first president. Voluntary contributions made up the largest part of financial assistance but the county granted $300 a year. With increase in public interest it was decided to investigate a more permanent location which could be enlarged with growth of the community and demand for services.

The present site on South Orange Street was selected and a frame building constructed. Occupied in 1913, it was adequate at the time but soon became crowded. The city was requested to take over the hospital which relieved the committee of this responsibility. In an election the City Council asked authority to issue $85,000 in bonds to pay off the debt and construct a new and adequate building. The bond issue carried, but because of many delays construction was not begun until 1927. The building opened one year later. The name was changed to Munroe Memorial Hospital in honor of the Association's first president who was also president of the Munroe and Chambless National Bank. Dr. J. H. Therrell served on the hospital board and supervised purchase and installation of equipment in the building.

The following year an editorial stated that it would not be too many years before increased facilities would be needed, a prediction which soon became fact. Again, many delays occurred but finally in 1956 a new wing was added. Thus, four times in its history the hospital had to be enlarged. In 1972 a fourth floor was added. At present, plans are underway to improve auxiliary services such as surgery, x-ray, emergency room and kitchen.

A second institution, Surgical Medical Hospital, with 30 beds was opened in 1972. It is a private hospital partially owned by a group of local physicians.

In the fall of 1973 the Medical Corporation of America opened a 125-bed hospital across the street from the Munroe Memorial Hospital. One wonders how soon increased facilities will be needed.

Outstanding Contributions

Five physicians from Marion County have

Fig. 2.—Marion County Medical Society 1973. (From left to right back row): Drs. William H. Lilly, Claude B. Henderson, Donald L. Smith, Thomas D. Guin, Eugene G. Peek Jr., George Ferre Jr., H. Lamar Roberts, Steve H. Gilman, William E. Chambers, John E. Boysen, James L. Stone, Edward Sabol, Robert C. Bartlett, and Edmond T. Strickland. (Second Row): Drs. John P. Moore, S. A. Moses Shashy, Waldo M. Wattles, West Bitzer, David C. Whittaker, Robert C. Childress, Frank R. Wilkerson Jr., William H. Anderson Jr., Henry L. Harrell Jr., Thomas Knippel, Henry Parrish, Cecil D. Riggs, Jesse G. Wright, Henry L. Harrell Sr., William C. Butscher Jr., Thomas H. Davis, and John P. Wahle. (Third Row): Drs. David C. Albritton, Frederick M. Yutani, Duke West, Carl S. Lytle, Sandra L. Price, Gertrude E. Warner, Margaret Palmer, Manuel Del Charco, Bobby A. Richardson, Ronald Fox, John D. Lindner, and Keith H. Knorr. (Front Row): Drs. Glen Neel, James L. McLaughlin and William T. Cobb.
(Not present) Drs. Sam L. Renfro, Robert E. Thompson, Pedro F. Rodriguez, John Haile, Ernest E. Lamb, Carlos A. Duran, Dean C. Kramer, George Ferre Sr., and Herbert M. Webb Jr.

served six terms as president of the Florida Medical Association: Thomas P. Gary, 1890 and 1891; (He died during his second term of office.) R. P. Izlar, 1898; A. H. Freeman, 1911; Henry C. Dozier, 1929, and Eugene G. Peek Sr., 1943. Although Marion County is proud to have had them selected to preside over the state association, there are others no longer living who by their skill and regard for humanity have made outstanding contributions.

Marion County is grateful to Dr. Sam P. Eagleton who saw the need for a hospital in 1897 and to Drs. Walter Hood, W. V. Newsom, J. L. Chalker and E. G. Lindner whose son, Dr. J. D. Lindner, is the third generation to practice in the area. Added to this list should be Drs. W. W. Henry, A. H. Freeman, Robin Kettles, J. N. Moore (father of Dr. John P. Moore, currently practicing in Ocala) T. K. Slaughter, W. K. Lane, J. Hood, Carney Mims, Dr. Russell, R. C. Cumming, Harry Watt, Robert Ferguson and William McGovern.

In 1947 Drs. Eugene G. Peek Sr. and Harry Watt were honored at a dinner held at Munroe Memorial Hospital. The hospital staff and Board of Directors presented a loving cup to each of them. Dr. Edward Jelks of Jacksonville, past president of the Florida Medical Association, and Dr. William C. Thomas of Gainesville, president, made the presentations and praised the physicians for their outstanding contributions.

The Marion County Medical Society had 34 members in 1964. The number did not indicate a remarkable increase but the quality was outstanding. Out of that comparatively small group were Dr. Eugene G. Peek Jr. who participated prominently in state and local organizations; Dr. William H. Anderson Jr., president of the Florida Society of Ophthalmology and Otolaryngology, and Dr. Harry M. Edwards, president of the Florida Pediatric Society. Dr. Edwin H. Updike served as president of the Florida Cancer Society and Dr. Henry T. Harrell as president of the Florida Academy of General Practice in 1956.

By 1973 the number of physicians had increased to 52; many had received recognition. Dr. Anderson completed five years as president of the Medical Advisory Committee to the Florida Council for the Blind and received a citation for long and devoted service to the Bureau of Blind Services. Dr. West Bitzer served as secretary and later as president of the Florida Society of Ophthalmology and Otolaryngology. Dr. Peek Jr. served as Speaker of the House of Delegates and vice president of the Florida Medical Association and as president of the Florida Medical Foundation and of the Florida State Board of Health. Dr. Steve Gilman was honored with the Service Above Self Award for outstanding civic contributions. Dr. Henry L. Harrell received the A. H. Robins Co. award for outstanding community service by a physician, Outstanding Citizen Award by Ocala Jaycees, and Golden Deeds Award from the Ocala Exchange Club.

Dr. Richard C. Cumming died in 1972. He had taken an active part in civic affairs and had received many honors. He served as mayor of Ocala for four terms and as district governor of Rotary International.

Acknowledgment

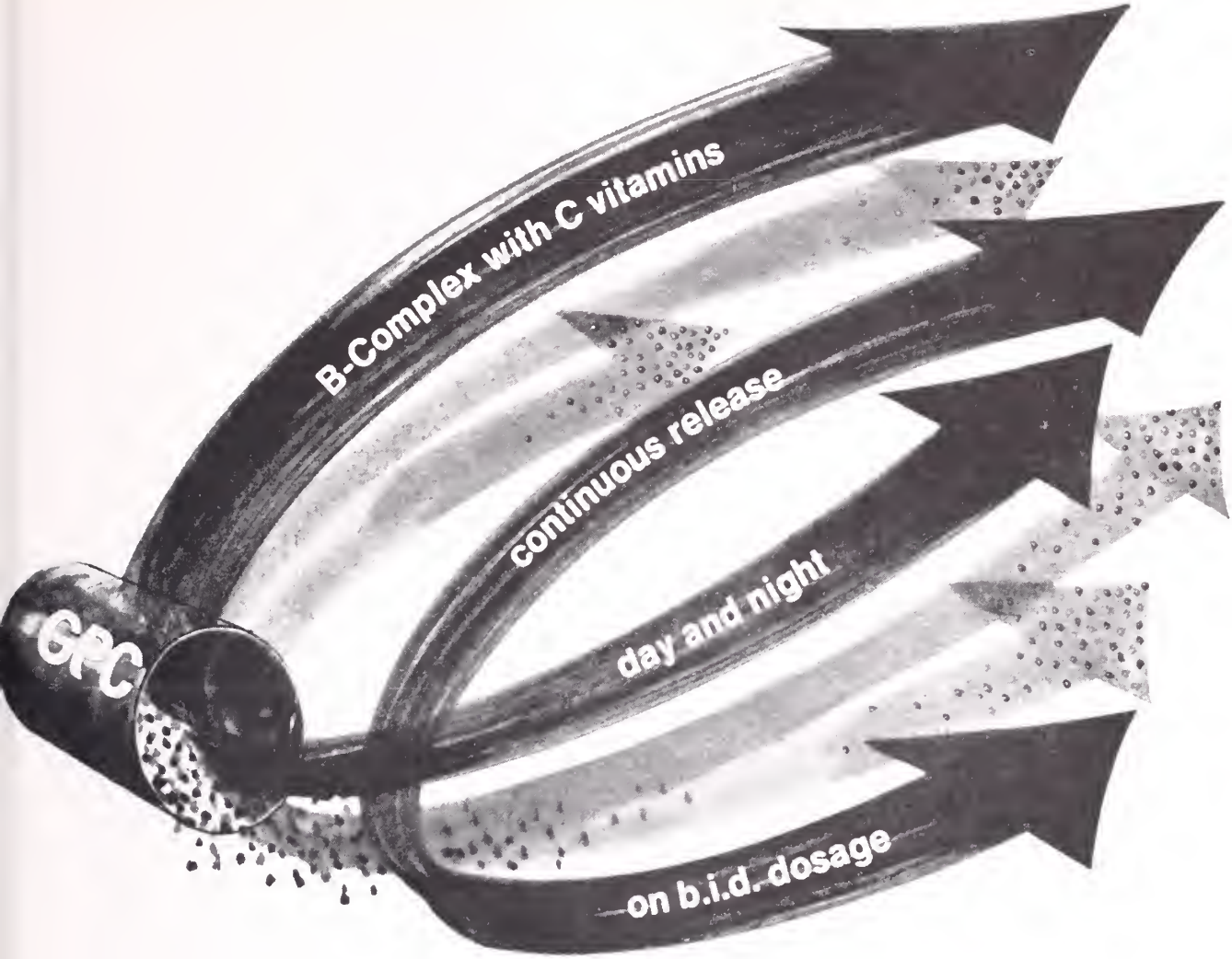
We are grateful to Miss Elizabeth Alexander, Director, P. K. Yonge Library of Florida History, University of Florida, Gainesville, and to Mrs. Ferguson, Historic Reference Librarian, Ocala Public Library.

Fisherman's Prayer

God grant that I may live to fish
Until my dying day.
And when it comes to my last cast,
I then most humbly pray,
When in the Lord's safe landing net
I'm peacefully asleep,
That in His mercy I be judged
As big enough to keep.

Author unknown

Reprinted from Guideposts, July, 1974.



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Special Articles

The Prescribed Medication Program (Medicaid)

MATTHEW E. MORROW, M.D.

On the first day of last month a private concern (PAID Prescriptions) began the processing and paying of claims for this program, so there seems little need at this time to recount its stark beginning or its tightly corseted growth. A review by the Bureau of Medical Services is to continue, however, and for at least six months the controversial cap of $20 a month per patient will remain.

The Prescribed Medication Program was initially designed as an *aid* in the payment of prescribed medications and was never intended to pay for all drugs. The provision for excess grants was made in order to distribute the funds made available by *legislation* as equally as possible to Florida's 400,000 recipients while still recognizing the need for additional help in certain grave and serious illnesses. For instance, at no time has the program failed to pay for antibiotics, antineoplastics or our time honored remedies for heart disease or diabetes.

But like the poet's response to the architecture of St. Paul's Cathedral, "he builded better than he knew," this program has greatly exceeded its original design by documenting not only the prescribing habits of doctors but by pointing out the need for recurrent if not continuing education in pharmacology for the practicing physician.

Apparently many physicians are dependent on the detail man as their primary source of information about new drugs, and the detail man (salesman) is not apt to include a drug's side-effects, adverse reactions, contraindications or dangerous interactions with other drugs in his packaged spiel about its attributes. Indeed, by doing a "script-survey" yourself you can learn what products are currently being pushed just as well as the detail man can ascertain how well his "pitch" is going or how near he is to reaching his sales quota.

Another revelation is the tremendous number of pills prescribed. At this very moment I am reviewing a request for payment for 25 different drugs for a patient with the single diagnosis "Neurodermatitis." This patient would have to take about 45 pills a day to utilize the supply prescribed. Here is another patient with coronary disease and emphysema who must take 120 Valium, 120 Elavil, 120 Compazine, 100 Fiornal, 20 Dilaudid and 30 Carbrital capsules to keep him breathing (*?*) for a month. And another with the diagnosis of chronic brain syndrome that must take 90 Valium, 90 Indocin, 90 Vasodilan, 60 Haldol, 90 Norpramine, 60 Thorazine, 120 Compazine and 60 Noctec a month to "help" his diagnosis. These are not exceptions. There are hundreds more like them and in some instances the reviewer can see the very history of illness unfold as foreshadowed by the drugs being prescribed. A common example is the *"indefinite"* use of Butazaldin, Indocin and Aspirin (yes, all three at once) and the predictable addition usually sooner than later of Maalox, Dramamine, Pamine and Phenobarbital and eventually on to Percodan and Fergon and . . . .

I have been "told" that any doctor should know that "all patients receiving diuretics must take potassium" when the diuretic being prescribed was Aldactone, but this doesn't worry me any more than the digitalized patient taking 180 pills of Lasix a month as well as Hydroduiril who is receiving no potassium. I can only recall the "Premum Non Nocere" and wonder what happened to Sir William Osler's warning that "one of the first duties of the physician is to educate the public *not* to take medicine."

In a recent study at the University of Florida College of Medicine it was found that approxi-

mately 3% of all admissions to the Shand's Teaching Hospital were made necessary by the medications being prescribed. Many chronic diseases are made worse, moreover, by drugs used to ameliorate less important symptoms like prescribing Thorazine for the patient with Parkinson's disease because of nervousness or using Prednisone for the diabetic with joint discomfort.

No where is the failure of the standard front-end educational load system more apparent in our profession than in this area and because of this, Lamar Crevasse, Dean of Continuing Education at the University of Florida College of Medicine, has promised to instigate annual seminars on "Drugs—Their Use and Abuse" with me for the practicing physician. This would no doubt help but I think we must do much more—even send out "detail men" of our own—if we are to really accomplish anything worthy of our profession.

In a recent edition of the Medical Letter on Drugs and Therapeutics one of the many drugs that supposedly re-establishes circulation and makes old folks think straight again was reviewed. I was impressed with their conclusion which simply stated that the beneficial effects of the drug fell far short of the good associated with a little warmth and human kindness. Medicine differs from all other specialties in that it is at best a service and no product need be exchanged with that service. Apparently many physicians have never fully appreciated this difference and feel compulsed to deliver something tangible (a prescription—an injection) to the patient in exchange for a fee like any other tradesman. Understanding, good advice or just plain sympathy is safer and in many instances far more effective than just writing a prescription for more drugs.

▶ Dr. Morrow, State Medical Consultant, Bureau of Medical Services, Division of Family Services, Dept. of Health and Rehabilitative Services, Jacksonville 32201.

How We Did It

Football Physicals

James H. Corwin, M.D.

Duval County (Jacksonville) Florida is an urban-surburban community of about half a million people. It is served by 13 senior high schools, all of which participate in intrascholastic football. Some predominately black schools had difficulty in obtaining medical examinations and help with their programs but after an upheaval by the federal courts in 1970, the problem became general. Accordingly, interested local physicians in connection with school officials worked out a plan for a mass physical exam program for all senior high school football teams. By using paramedical personnel from a local Army Reserve Hospital Unit, a remarkably complete exam was given, far superior to the previous brief exams given by individual physicians working alone.

This program has now been in operation for two years and we have made some observations which may be of help to others.

The program was set up to give physical exams to all senior high football candidates and was scheduled for the first Saturday after football practice started. The exam was given at one of the local high schools and all teams were transported there by bus or auto convoy and each team was scheduled for a specific time. We found that we could examine one team of 40 to 60 boys in 30 to 45 minutes and scheduled each team at approximately ½ hour intervals. The candidates themselves were all senior high (10th, 11th and 12th grades) students, most of whom had played football before and had been examined in former years. In 1972, 680 students were examined and in 1973, 661 were examined, making a grand total of 1341 for the two years. Twelve physicians participated in 1972 and 15 in 1973, and each worked about two hours. The program was sponsored by the School Athletic Committee of the Duval County Medical Society. About 25 corpsmen from

the local Army Reserve Hospital Unit participated and credit for a regular duty day was received from their unit. Necessary equipment was provided by the school system, Army Reserve Hospital, and individual physicians. The few supplies such as tongue blades and urinalysis sticks were donated. In all, out of pocket cash expense was not more than $50 each year including coffee and donuts.

Procedure for the examination was set up so that each student filled out a short history at the top of a printed form (supplied by the school system) and then carried this form through the different stations of the exam and had all findings recorded. The stations were: 1. Measurement, 2. Vision, 3. Head and neck, 4. Chest and heart, 5. Abdomen and hernia, 6. Urinalysis, and 7. Orthopedic.

The measurements, height, weight, pulse, and blood pressure, were entirely carried out by the corpsmen as was the vision exam. Head and neck including ears and throat; chest and heart; and abdomen and hernia examinations were all carried out by physicians in teams of two. An orthopedist examined each student who gave a history of an orthopedic injury or had a visible defect. The urinalysis exam was entirely carried out by the corpsmen using commercially available urine sticks which screened for glucose and protein. One physician completed the examination forms at the end of the exam and all students were either approved or not approved. No student was "failed" or "rejected" for football, but merely informed that he had an abnormality for which he must see his private physician and either be approved or disqualified for football by that physician.

Results

In 1972 a total of 11 students out of 680 were not approved and in 1973, 14 out of 661 were not approved. This is a rejection rate of about 2%, but some of the abnormalities were quite significant (Table 1).

TABLE 1.—1341 EXAMINATIONS; 1972 AND 1973 COMBINED

Abnormalities	
Heart	3
Urine Glucose	6
Urine Protein	5
Inguinal Hernia	4
Hypertension	6
Blindness, one eye	1

Complete follow-up was not attempted, but casual inquiry has revealed that one student with a heart murmur was found to have severe rheumatic heart disease and another was found to have a congenital heart defect which has since been surgically repaired. Two of the students with urinary glucose were found to have diabetes requiring treatment, one student with proteinuria was found to have acute nephritis, and two had acute ureteritis. The family of the student who was blind in one eye was unware of this although the student was aware of it. The hypertension was interesting, all six cases occurring in American Negroes, five of whom were grossly obese. Two of these students are known to be under medical treatment for hypertension at the present time. This is a rather significant amount of pathology in a young apparently healthy group of student athletes, almost all of whom had had at least one previous physical examination.

We who have participated in this program have been impressed with its efficiency and the completeness of the exam we were able to offer in comparison with our former efforts. We have also been pleasantly surprised at the rapidity and efficiency with which the examinations could be performed using paramedical personnel. We plan to continue this program and in 1974 to extend it to the junior high school football program.

Perhaps our experience with this exam can be helpful to other areas faced with problems and it has made us discuss and surmise that the same type program could be used to offer screening physical exams to all school children.

▶ Dr. Corwin, 3599 University Boulevard, Jacksonville 32216.

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Editorials

Why Have a State Journal, Anyway?

Physicians have more to read than is practical to do so. Specialty and general journals are more appealing. State medical associations should not duplicate efforts of regional and national associations. State journals never print anything interesting. How often have you heard these or similar remarks?

Why, indeed, have a state journal? Perhaps a statement of purpose would be in order to set the record straight.

If regionalization of state journals involved *The Journal of the Florida Medical Association,* your Journal would lose its unique personality. These pages presently present some of the hopes, aspirations and endeavors of individual physician members. They give us a chronicle of activities of our state medical leaders. These pages also summarize the deliberations of the Board of Governors, House of Delegates and numerous committees. Excellent photographs, especially of the Annual Meeting, enliven the pages. Occasional touches of humor grace the letters to the editor.

Why, indeed, have *The Journal of the FMA?* Because we must!

F. Norman Vickers, M.D.
Pensacola

More Thoughts Along the Same Line

To answer the preceding editorial, perhaps some repetition may be helpful in defining as well as explaining the role of our state *Journal.* It obviously is the official organ of the Florida Medical Association until the House of Delegates decrees otherwise, and as such performs many useful functions.

The Journal serves as an educational vehicle for publication of scientific papers, written by both private practitioners and faculty practitioners from our medical schools.

The Journal should publish proceedings of the annual meeting of the House of Delegates. Over the years, serious attempts have been successfully made to carefully transcribe and edit these transactions. This is done in hopes that any member of the FMA, though not having attended the meetings could by reading *The Journal,* be better informed on the actions of the House of Delegates. Getting this material into print while it is current is delayed by the time lag necessary to transcribe, type and correct it before it goes to the printer where another 10 to 14 days is needed to set it in type, do the layout on it, get it addressed and into the mail. Methods of reducing this time lag, using innovative systems, are a perennial subject of discussion among the editorial staff.

The Journal serving as a media of communication in FMA could be improved with more articles on timely subjects designed to keep readers abreast of the affairs of organized medicine in Florida. This, the President now does on his page but other officers, council and committee chairmen, as well as members of the Board of Governors could use *The Journal* to educate members as to how problems confronting the organization are solved. For *The Journal* to become a more effective means of communication, other ingredients are necessary. A well informed practitioner as editor is vital, one in whom the Board of Governors has implicit confidence. Needed also

is a voluntary group of assistant and consulting editors who take their appointments seriously by using their talents or persuading others to aid them in improving *The Journal.*

A continuing source of revenue must be assured so that a revenue deficit above the cost of publication will not hamstring the aspirations of the editorial staff in striving to publish a better Journal. At the present, other sources of revenue are being sought, for pharmaceutical manufacturers now supply only about three quarters of the expense of publishing *The Journal,* yet they avow that one function of *The Journal* should be physician education about prescription drugs. If this industry sought product peer review under endorsement from the AMA Council on Drugs, such advertising would assume valid educational status.

With the new FMA membership requirements of continuing medical education, it appears that *The Journal* has a mandate to cooperate with the CME committee by developing and providing more sophisticated techniques of information collection, dissemination, storage and retrieval. The essential problem being how best can information be communicated effectively and rapidly. The accumulation of information and the growth of knowledge are problems that medical journals, with their cohesiveness, cross-fertilization of knowledge and potential for serendipity, can overcome.

To enter and keep up in continuing education requires reading current and diverse medical literature. Obviously, there is too much to read, too many articles and too many journals. Reading one's specialty journals, even a select few, is not the answer. A constant review of 10 to 12 selected journals would be necessary to keep the physician abreast of advances. So, why could not a state journal do this by becoming part of an orderly input of information into a medical communication system, and avoid haphazard communication of information? Cooperation among specialty societies and national medical organizations with emphasis on delineation of areas of responsibilities and appropriate sharing of information, could lead to the development of a nationwide compendium and ultimately an international system of communication of information.

Finally, state journals, in a readable form, should write on the art of the practice of medicine. Medical ethics, reasonable fees, good doctor-patient relationships, the responsibilities of the referring doctor, the attending doctor and the the doctor called in consultation, need to be discussed and recorded. The procedures needed to obtain medical liability insurance and the pitfalls of such coverage would be of educational interest.

As everyone needs the day-to-day stimulus of striving toward new goals, could not *The Journal* join with our Committee on Continuing Medical Education to aid in solving another problem, that of motivating physicians to read *The Journal?*

With the increasing popularity of audiovisual teaching, some predict that medical journals will take a place in museums alongside Caxton's printing press. At this writing, however, it appears that learning depends more on comprehending and memorizing facts which can more economically and more efficiently be obtained from the illustrated printed page. Although the old order may be changing, nevertheless, medical journals with their cumbersome, time-consuming process of publication will continue to be needed. Whether this is borne out depends on you, our readers.

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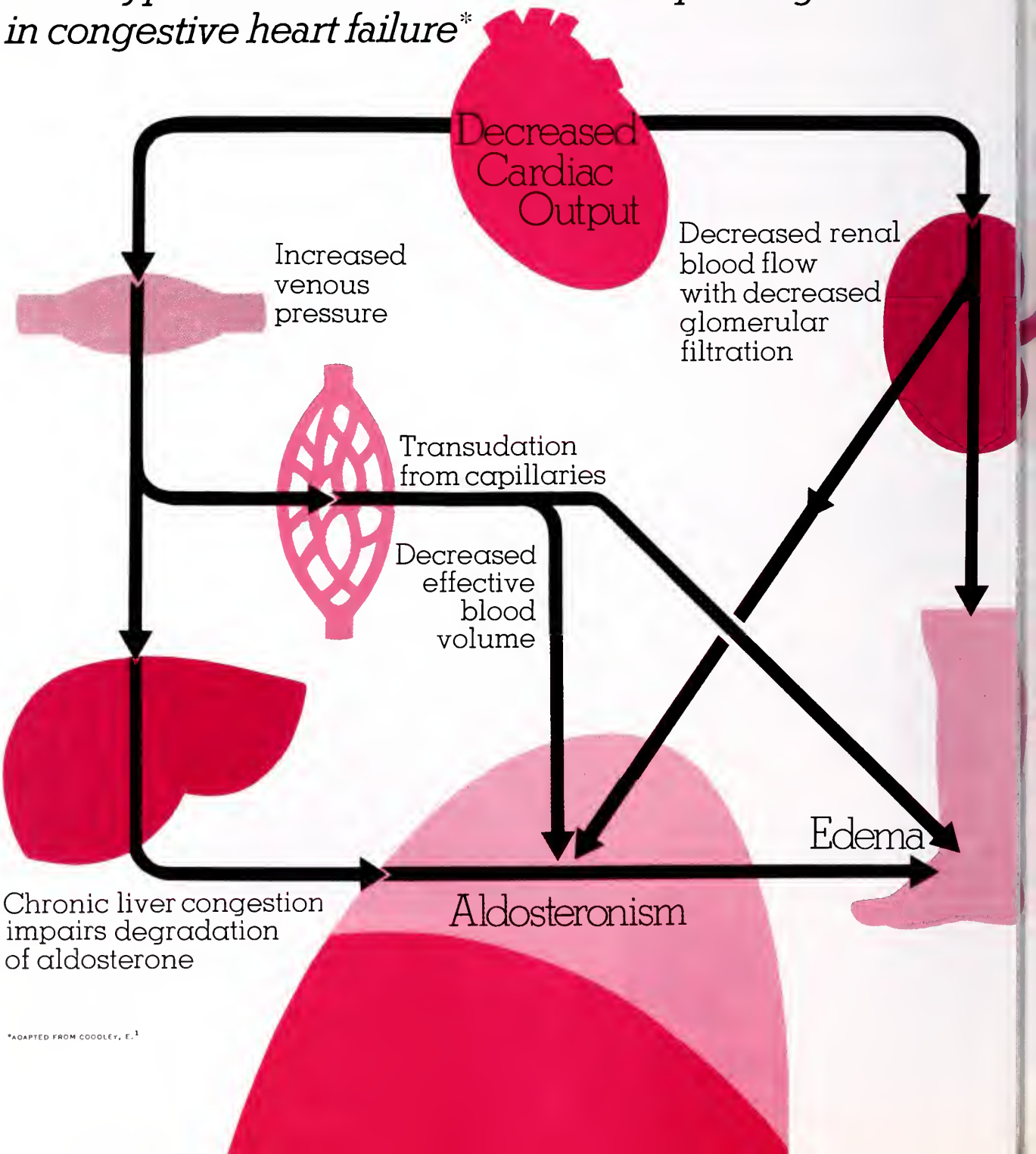

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- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannital or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannital is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E. Consultant 12 106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Louler, D. P. Am. J. Med. 53 673-684 (Nov.) 1972

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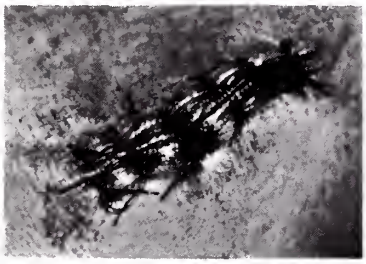

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Schedule:

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Registration will be limited, therefore, priority will be given to applicants enrolling for entire course.

For information and application write to:
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ORGANIZATION

E. Charlton Prather, M.D., M.P.H., Director Florida State Division of Health

DR. PRATHER

The retirement of Dr. Wilson T. Sowder as Florida's long-time leader of public health left his associates with a feeling of irreparable loss. But with announcement of the designation of Dr. E. Charlton Prather as his successor, uncertainty and anxiety were replaced by confidence and pleasant expectation. From the low to the high there was virtually unanimous approval. When this appointment was made known at a national meeting in the Center for Disease Control in Atlanta, there was a spontaneous burst of applause. The physicians in Florida join in these expressions of satisfaction for Dr. Prather was recommended for this appointment by the Florida Medical Association.

I first met the incoming Director of the Division of Health when I was head of the Bureau of Laboratories and he, a Florida boy from Jasper, was a candidate for his Master's degree in microbiology at the University of Florida. He sought employment but more than this he wanted an opportunity to be of service to the people of his home state; he saw that opportunity in the field of public health. At that time he planned to continue to his Doctorate in microbiology. His interest and competence in this field were immediately apparent. But so was the excellence of his personal relationships. He was a friend of all. Obviously his attributes were those which would

be a major asset to a physician. The argument which changed the direction of his professional training was that in public health a physician would have broader opportunities than a scientist.

Wtih medical training not yet available in Florida, he readily obtained admission to the Bowman Gray School of Medicine. But the way was not easy. Economically, he and his bride, Annie Lou, were dependent on their own resources. They managed, Annie Lou as a nurse and Charlton with a part-time appointment in microbiology during the school year and full-time during the summer.

Despite the emphasis on clinical medicine in medical schools, Dr. Prather graduated with a firm commitment to public health. At that time the Board of Health had a training grant to provide support to those entering this field. This permitted planning a three-year period of training considered to be the best available experience for physicians in public health. This began at Jackson Memorial Hospital in Miami where its director shared in designing a special internship emphasizing clinical fields of particular importance to public health, including work in health department clinics and a short assignment with the late Dr. T. E. Cato, Health Officer of Dade County. There followed 12 months of graduate training at the University of North Carolina School of Public Health and an additional year as a resident in public health under direction of Dr. John Neill in Hillsborough County.

Dr. Prather's experience in the Division of Health has been one of progressively increasing responsibilities. His work in the Bureau of Preventable Diseases brought him into repeated contact with the staffs in county health departments and hospitals and with medical practitioners throughout the state. In this large Bureau he further developed his natural aptitude for administrative management.

His home is in Orange Park, and there he has been a very active member of the Clay County Medical Society, having been President and currently as Secretary. In the Florida Medical Association he has served for multiple terms in the Public Health and Environment Committee and at present is a Consulting Editor of the Journal.

Dr. Prather's abilities and promise have been recognized elsewhere. He has been urged by physicians to join them in private practice. On two occasions he was invited to consider the position as health officer for two western states. One of our southern medical schools sought his service as head of the Department of Preventive Medicine and Public Health. He elected to continue to serve in public health in his home state.

His personal qualities match his outstanding professional attainments. With an attractive wife and two maturing sons, his is a very exceptional family. Outside his public health work, major interests are his home, church and community. His avocation is with tools which he uses with the skill of a master builder in improving his home environment.

Florida has had a state health officer and a public health program acknowledged to be the best in the land. The Selection Committee, Secretary Keller and Governor Askew are to be commended in recognizing in Dr. Prather one who will maintain this high standard and continue the progressive improvement in the public health program. His is a difficult but challenging task. He will need strong support from all public health workers and administrators, from legislators in Tallahassee, medical practitioners throughout the state and the public. This will be eagerly provided by those who know him and will be readily given by all as he becomes better known. Florida can be proud of one of its own.

Albert V. Hardy, M.D.
Medical Consultant in Research
Florida Division of Health
Jacksonville

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Dr. Nagel Gets AMA Post

Eugene L. Nagel, M.D., of California, a former Assistant Editor of *The Journal* has been elected Chairman of the American Medical Association's Commission on Emergency Medical Services. He represents the American Society of Anesthesiologists on the Commission.

Earlier this year, Dr. Nagel resigned his post as Professor of Anesthesiology at the University of Miami School of Medicine and moved to California to become Chairman of the Department of Anesthesiology at Harbor General Hospital in Torrence.

Residents Get SMA Grants

Two physicians in residency training programs in Florida are among nine recipients of Southern Medical Association training grants.

They are Stephen B. Berrien, M.D., resident physician at Hope Haven Children's Hospital in Jacksonville and Joel M. Engelstein, M.D., who is in training at the University of Florida.

The Residency Training Grant and Loan program was established in 1962 as part of SMA's continuing efforts to develop and foster scientific medicine.

ACA Fellows

The American College of Anesthesiologists has certified five Florida physicians as Fellows. They are: Guillermo Francisco Carrillo, M.D., Lake Worth; Jesus J. Garcia-Guerra, M.D., Miami; Anthony D. Migliore, M.D., Fort Myers; Richard L. Nutt Jr., M.D., Jacksonville; and William David Nunez, M.D. of Miami.

ACS Meeting at Miami Beach

The American College of Surgeons has released preliminary information on its 60th Annual Clinical Congress, which will be held in the Miami Beach Convention Center, October 21-25.

ACS predicts that almost 20,000 persons will attend the sessions. Among program features will be 17 postgraduate courses; more than 260 research-in-progress reports called the Forum on Fundamental Surgical Problems; more than 50 panel discussions and symposia on general surgery and surgical specialties; live telecasts of operations at Jackson Memorial Hospital in Miami; more than 130 films; and in excess of 350 exhibits.

Information may be obtained from the American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611.

New Chairman of Community Hospital Education Council

Thornton A. Beckner, M.D., Director of Medical Education for Florida Hospitals in Orlando, has been elected chairman of the Community Hospital Education Council, replacing Frank C. Coleman, M.D. who had held the position since the Council was appointed.

Dr. Beckner, a 1955 graduate of Loma Linda University School of Medicine, has been active in graduate medical education for many years. He is certified in obstetrics and gynecology.

Trio Honored

The Florida Committee on Smoking and Health has honored three members of the Florida Medical Association for 10 years of service. They are: Charles Tate, M.D., Associate Professor of Medicine at the University of Miami School of Medicine; DeWitt Daughtry, M.D., of Miami; and James Fulghum, M.D., an official of the Florida Division of Health, Jacksonville.

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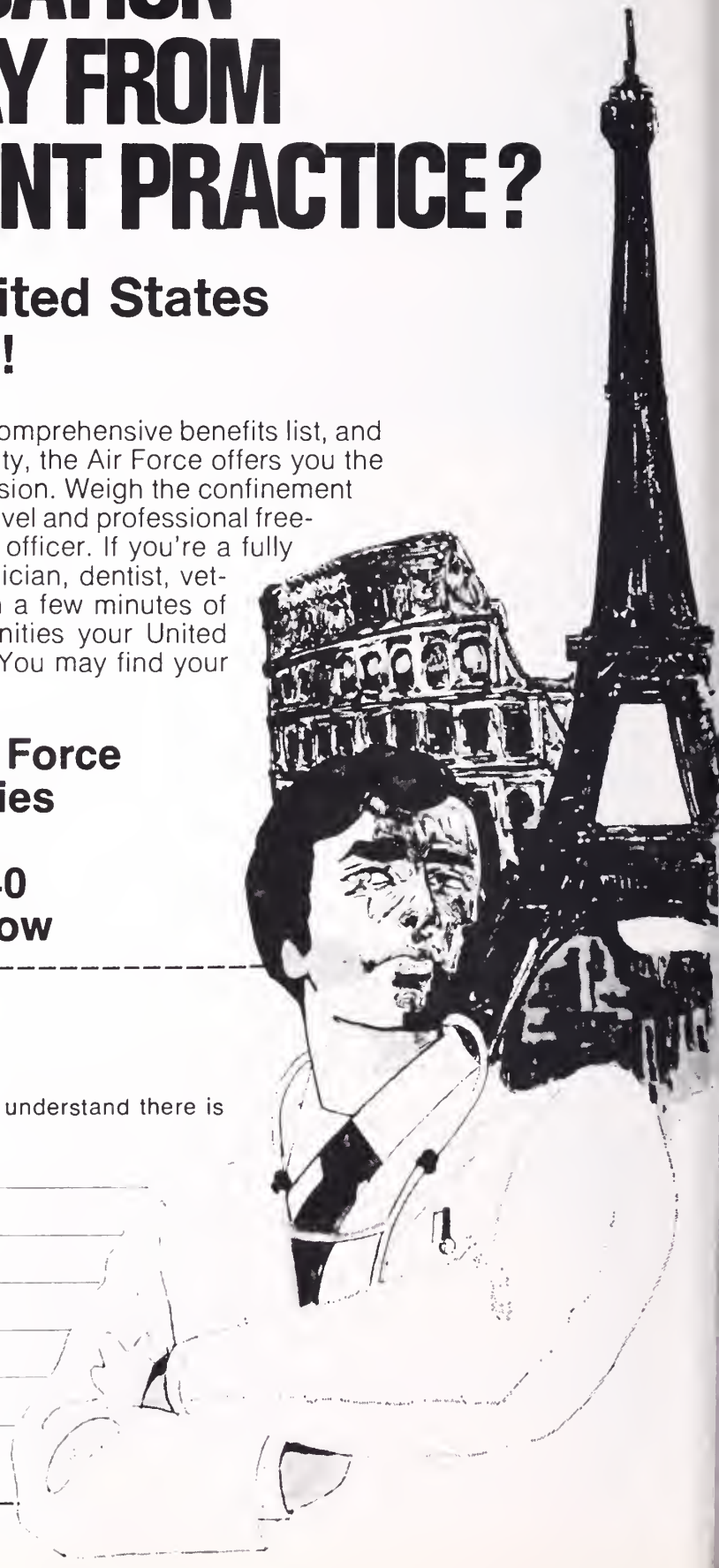

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Billy Brasher, M.D.

Is it reasonable that in some manner each person so desiring should be able to budget for usual and unusual and customary and uncustomary expenses through prepayment? I believe it is; obviously the public and majority of physicians and legislators believe it is. The major question is: "Will it be the government or the private sector which responds to a real need?"

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The point I wish to make is that acceptance of UCR by me and by the medical profession must be to some extent a political decision. While subject to some inflexibility, some unfairness, and our own Blue Shield bureaucracy, it undermines the arguments for government takeover by providing cost predictability to the insured and the insuror, physician and patient freedom of choice, and a method of allowing fees to change in relation to the market and general economic picture. It demonstrates to the patient (the public) the ability of private medicine to provide these traditional prerogatives of patients and physicians on a prepayment plan.

Accepting and utilizing UCR helps give us a viable palatable alternative to offer the nation when confronted by the various pie-in-the-sky proposals. Think it over.

▶ Dr. Brashear, 225 S. W. 7th Terrace, Gainesville 32610.

Dr. Brashear is a member of the Blue Shield Board of Directors.

Book Reviews

What I Expect of My Children by Carl E. Andrews, M.D. Price $3.95. A Hearthstone Book, New York, Carlton Press, 1972.

Approximately a year and a half ago a member of the Florida Medical Association handed me a book saying he thought I might be interested in it. I placed it alongside several others atop my bedroom bookcase, making a mental note to read it. The book was forgotten until last summer when one of my youngest sons started planning to go to a camp in Pennsylvania where he had a job as a counselor. He asked me if I had anything he could use for devotional periods or campfire programs. Looking around the bedroom at the Journals and books stacked around, I found this one and gave it to him with the request that he return it to me for I hadn't read it. Before he took the book I glanced at the table of contents, which started off with these words. "I expect my children to:" and 17 chapters which followed: (1) Grow up to the Scout Laws and to "If," (2) Live by the golden rule and the ten commandments, (3) Love by the 13th chapter of I Corinthians, (4) Support and defend the Constitution of the United States, (5) Maintain good health, (6) Be educated, (7) Work, (8) Play, (9) Rest, (10) Be polite, (11) Be happy, (12) Have friends, (13) Marry, (14) Have a family, (15) Be religious, to say the Lord's Prayer, (16) Say the twenty-third psalm, (17) Leave the world a little better for having lived in it, and, followed by the Index.

When my son returned from camp, I had an opportunity to read the book at my leisure. In it are quotations from the great men of our country, including Henry Wadsworth Longfellow, Patrick Henry, Abraham Lincoln and Benjamin Franklin. It's a book to read anytime you are down in the dumps, anytime you need an inspiration, or anytime you need a quotation to illustrate a lecture. Of course, the Gettysburg address is there and the 13th chapter of I Corinthians. One of my favorites is "The Game of Life," a chaplain's advice to one of his young pupils, in which he compares life to a football game. He names his pupil as the quarterback and describes the game which lasts all one's life with no time out. The backfield, named Faith, Hope and Charity, operates behind a powerful line consisting of honesty, loyalty, devotion to duty, self-respect, study, cleanliness and good behavior. The chaplain hands his pupil the ball with these words: "The goal posts are the pearly gates of heaven. God is the referee. He makes all the rules. They are known as the ten commandments. There is one important ground rule. It is, "Do unto others as you would have them do unto you." In this game, if you lose the ball, you lose also, the game. Here is the ball. It is your mortal soul."

C.M.C.

Comments in Sports Medicine edited by Timothy T. Craig, Ph.D. 230 Pages. Illustrated. Price $5.00. Chicago, American Medical Association, 1973.

This volume, published by the AMA presents in concise form a review of the current knowledge on sports medicine. It is designed primarily for those people who are confronted with the improving and developing the athletic performance of our young people in competition; and to aid those who seek the full enjoyment of recreation. Nearly all our sports professionals began their career in our high schools and colleges. If we can teach them, and those who care for them the rudiments of safety, injury prevention and basic treatment of injuries received during their endeavor, we will go a long way in helping them reach their full potential. Most sports professionals are well paid in this country, and for an economic reason alone it is important to see that they will be able to perform at full capability. This volume contains not only the nature of athletic injury and illness, but presents the results of scientific research to better understand the basic processes.

I highly recommend this book, and hope that the AMA will continue to update the information as it becomes available.

Floyd K. Hurt, M.D.
Jacksonville

Post-Mortem by David M. Spain, M.D. with Janet Kole. 296 Pages. Price $7.95. Garden City, N. Y., Doubleday & Company, Inc., 1974.

The day of the pathologist has dawned. Pathologists have never been reluctant to communicate with each other and their medical colleagues through articles, periodicals, magazines and books. The traditional pathologist has, at least in the United States, stayed pretty much out of the public eye. The novel "The Final Diagnosis," captured the public's fancy a few years ago and the pathologic intricacies of the Coppolino trial further whetted the public appetite for the gruesome. Now biographies or semibiographies of forensic pathologists are being exhumed, cosmetized and offered up to satisfy the macabre tastes of the general public. One such book is "Post Mortem," written (with apparently considerable editorial assistance) by a self-styled civil rights pathologist. The apparent champion of the underdog, the author has "investigated" the medical aspects of the death of civil rights workers in Mississippi, the Chicago Panthers deaths, and the Attica Prison affair. He also has participated in or reviewed controversial matters about autopsies. The authors measure the work of his colleagues, the law enforcement agencies, public officials and finds them, almost without exception, sadly lacking in objectivity, honesty and understanding of human rights. Fortunately, he is satisfied that his endowments along these lines are quite satisfactory and his basic job is to set the record straight. In this reviewer's opinion, a smaller book "The Medical Detectives," by Paulette Cooper, explores the realm of forensic pathology with greater objectively and clarity. Also the prose is far superior.

Courtlandt D. Berry, M.D.
Naples

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

The Ethics of Genetic Control, Ending Reproductive Roulette by Joseph Fletcher. 240 Pages. Price $1.95. New York, Anchor Press/Doubleday, 1974.

Handbook of Poisoning by Robert H. Dreisbach, M.D., Ph.D. 517 Pages. Illustrated. Price $6.50. Los Altos, Calif., Lange Medical Publication, 1974.

Hyperbaric Oxygenation—The Uncertain Miracle by Vance H. Trimble. 236 Pages. Illustrated. Price $6.95. Garden City, N. Y., Doubleday & Company, Inc., 1974.

Cardiovascular Diseases, Guidelines for Prevention and Care edited by Irving S Wright, M.D. and Donald T. Fredrickson, M.D. 404 Pages. Price $6.95. Washington, D. C., US. Government Printing Office.

The Malnourished Mind by Elie A. Shneour. 216 Pages. Price $6.95. Garden City, N. Y., Anchor Press/Doubleday, 1974.

Arthritis, Complete, Up-to-Date Facts for Patients and Their Families by Sheldon P. Blau, M.D. and Dodi Schultz. 176 Pages. Price $5.95. Garden City, N. Y. Doubleday and Company, 1974.

Aphasia, My World Alone by Helen Harlan Wulf. 144 Pages. Illustrated. Price $7.50. Detroit, Wayne State University Press, 1973.

Emergency Medical Services: Behavioral and Planning Perspectives edited by John H. Noble Jr., Ph.D.; Henry Wechsler, Ph.D.; Margaret E. LaMontagne, M.S.N and Mary Anne Noble, D.N.Sc. 595 Pages. Illustrated. New York, Behavioral Publications, 1973.

Current Pediatric Diagnosis & Treatment, 3rd Edition by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,020 Pages. Illustrated. Price $12.00. Los Altos, California, Lange Medical Publications, 1974.

The Ultimate Stranger-The Autistic Child by Carl H. Delacato, Ed.D. 226 Pages. Price $6.95. Garden City, N.Y., Doubleday & Company, 1974.

Medicine on the Santa Fe Trail by Thomas B. Hall, M.D. 160 Pages. Illustrated. Dayton, Ohio, Morningside Bookshop, 1971.

Stress Without Distress by Hans Selye, M.D. 174 Pages. Illustrated. Price $6.95. New York, J. B. Lippincott Company, 1974.

Essays on Longevity by Samuel Kahn, M.D. 198 Pages. Edited by Dagobert D. Runes. Price $6.00. New York, Philosophical Library Inc., 1974.

Free As a Bird by Philip Wills. 246 Pages. Illustrated. Price $13.50. New York, Barnes & Noble, 1974.

Awakenings by Dr. Oliver W. Sacks. 249 Pages. Price $7.95. Garden City, New York, Doubleday & Company, 1974.

Information for Authors

Manuscripts should be submitted to the editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

MEETINGS

Approved by FMA Committee on Continuing Medical Education

AUGUST

Postgraduate Obstetric-Pediatric Seminar, Aug. 15-17, Pier 66 Hotel, Fort Lauderdale. For information: A. F. Caraway, M.D., P.O. Box 210, Jacksonville 32201

Diagnostic Radiology for the Emergency Department, Aug. 18-23, Sheraton Olympic Villas, Orlando*

▶ Western Hemisphere Nutrition Congress IV, Aug. 19-22, Americana Hotel, Miami Beach. For information: AMA Council on Foods & Nutrition, 535 N. Dearborn St., Chicago 60610

Pediatric Postgraduate Seminar, Aug. 27, Tallahassee Memorial Hospital, Tallahassee. For information: Tallahassee Memorial Hospital, Tallahassee 32306

"Growth, Growth Diagnosis and Pediatric Endocrinology," Aug. 30-31, Sacred Heart Children's Hospital, Pensacola. For information: Pensacola Educational Program, 5151 N. Ninth Ave., Pensacola 32504.

SEPTEMBER

Teaching Conference in Radiology, Sept. 11-15, Doral Country Club, Miami*

Postgraduate Seminar in Pediatric & Adult Urology, Sept. 23-26, Playboy Plaza Hotel, Miami*

Third Annual Postgraduate Course in Gastroenterology (Dates not decided), University of Miami School of Medicine*

By Arrangement: In-Service Tutorials in Family Medicine; Neonatology; Oncology, Ophthalmology; Otolaryngology; Pediatric Cardiology; Radiology; Renal Disease, Hypertension and Renal Dialysis; Urology*

By Arrangement: On-Site Community-Hospital Program: "A Positive Approach to Cancer Diagnosis and Treatment." University of Miami School of Medicine, the Comprehensive Cancer Center of Greater Miami, National Cancer Institute, U.S. Public Health Service, and cosponsored by the American Cancer Society, Florida Division*

By Arrangement: Visiting Lecturers Program—a program designed to provide continuing education based on specific requests from local medical groups and hospitals*

OCTOBER

Fundamental and Clinical Aspects of Internal Medicine, Oct. 6-19, Sheraton Four Ambassadors Hotel, Miami*

▶ American College of Gastroenterology, Oct. 20-23, Americana Hotel, Miami Beach. For information: Mr. Daniel Weiss, 299 Broadway, New York 10007

▶ American College of Surgeons, Clinical Congress, Oct. 21-25, Miami Beach. For information: C. Rollins Hanlon, M.D., 55 E. Erie St., Chicago 60611

Reconstruction in and About the Orbit, Oct. 25-26, Innshooke, Florida (Tampa area), University of Florida College of Medicine**

Intensive Colposcopy, Oct. 25-27, Sonesta Beach Hotel, Key Biscayne*

Program for Foreign Medical Graduates, Oct. 28, University of Miami*

▶ American Society of Therapeutic Radiologists, Oct. 30-Nov. 4, Sonesta Beach Hotel, Key Biscayne. For information: Sheila A. McGing, 20 N. Wacker Dr., Rm. 2920, Chicago 60606

NOVEMBER

▶ Interstate Postgraduate Medical Association of North America, Nov. 4-7, Diplomat Hotel, Hollywood. For information: Mr. Roy T. Ragatz, Box 1109, Madison, Wisc. 53701

Hand Surgery—1974, Nov. 15-17, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Miami*

▶ American Association for Clinical Immunology and Allergy, Nov. 21-24, Pier 66, Ft. Lauderdale. For information: John L. Dewey, M.D., P.O. Box 912, DTS, Omaha, Nebraska 68101

Progress and Prospects in Health Care Distribution Systems, Nov. 25-27, Fontainebleau Hotel, Miami Beach*

DECEMBER

"Changing Concepts in Infectious Diseases for Obstetrics & Gynecology," Dec. 5-6, Hilton Hotel, Gainesville**

▶ Southern Surgical Association, Dec. 9-12, Boca Raton. For information: W. Dean Warren, M.D., 1364 Clifton Rd., N.E., Atlanta, Ga. 30322

13th Biennial Cardiovascular Seminar—"Tools and Techniques of the Practicing Cardiologist," Dec. 12-14, Sheraton Four Ambassadors Hotel, Miami. For information: Thomas J. Noto Jr., M.D., 5080 Biscayne Blvd., Miami 33137

JANUARY

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 22-25, Hyatt House, Miami Beach*

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▶ National meetings being held in Florida.

Other Approved CME Meetings

Neonatal Care — 1974 (Wednesday) 7:30 p.m.-10:00 p.m., Tampa General Hospital, Tampa

Pediatric Grand Rounds (Friday, holidays excluded) 9:15 a.m.-10:00 a.m., University Hospital, Jacksonville

Pediatric Conference (Wednesday) 9:15 a.m.-10:00 a.m., Jacksonville Children's Hospital, Jacksonville

Graduate Level Courses in Family Practice (Weekdays), University of Miami School of Medicine*

Weekly Teaching Conferences (Tuesday), Morton E. Plant Hospital, Clearwater

Peer Teaching Conferences (Wednesday), St. Vincent's Hospital, Jacksonville

In-Service Tutorial in Pediatric Cardiology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Neonatology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Radiology (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer Diagnosis & Treatment (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer In-Hospital Training Program (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Otolaryngology (Arranged), University of Miami School of Medicine*

Family Practice Grand Rounds (1st 3 Thursdays), St. Joseph's Hospital, Tampa

Consultant Teaching Seminars (Weekly), Alachua General Hospital, Gainesville

In-Service Training in Family Medicine (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Cardiology (Arranged), University of Miami School of Medicine*

Courses of Instruction in Coronary Care for Practicing Physicians (Arranged), University of Miami School of Medicine*

Practical Aspects of Family Medicine (Arranged), University of Miami School of Medicine*

Cardiac Conference (Tuesday) 4:30 p.m.-5:30 p.m., North Florida Regional Hospital In-Service Classroom, Gainesville

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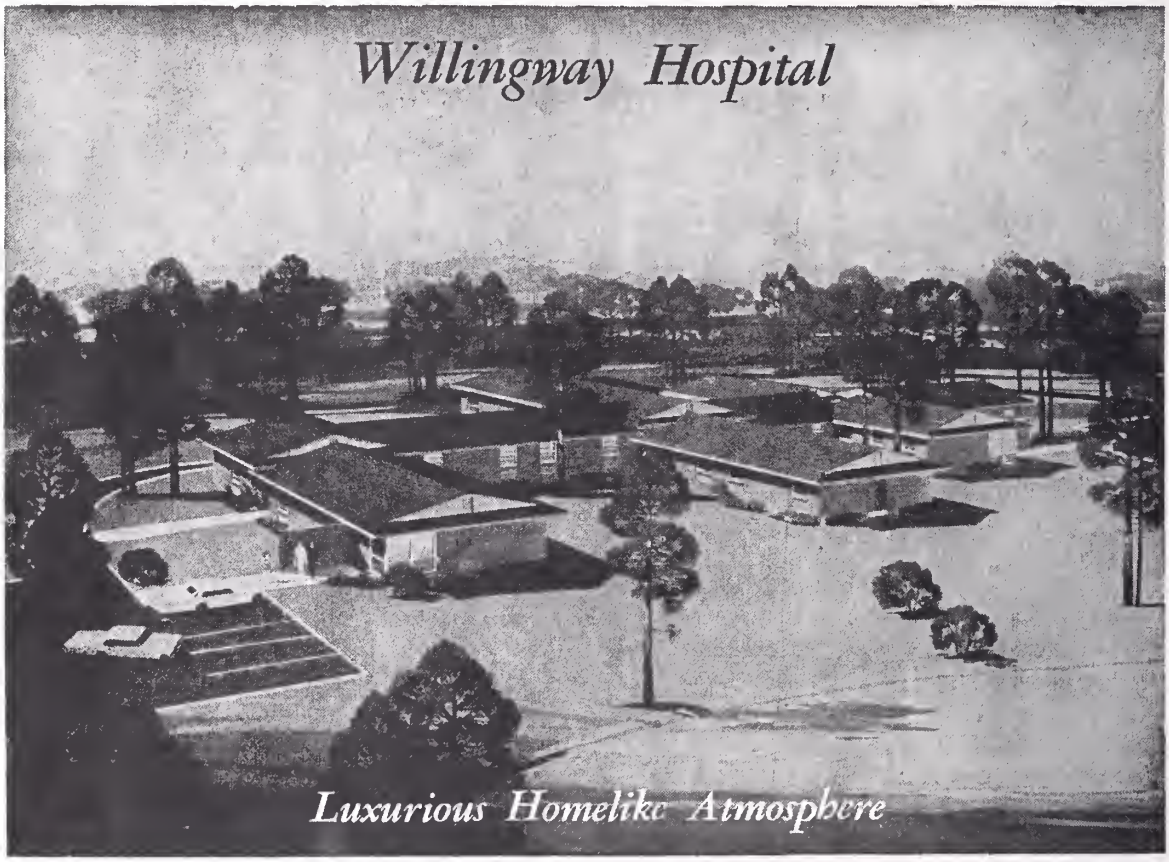

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GENERAL PRACTITIONER needed by expanding multispecialty group in northwest Florida. Excellent opportunity for U.S. trained physician. Guaranteed salary, then partnership. New hospital just opened, new clinic building being designed. Contact J. C. Wilson, M.D., P.O. Drawer MM, Ft. Walton Beach, Florida 32548.

GENERAL PRACTICE: Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

GENERAL PRACTITIONERS AND INTERNISTS NEEDED. Very desirable southeast coast community. Excellent hospital facilities. Florida license required. Inquiries regarding practice in our county can be sent to Box 324, Stuart, Florida 33494. Phone: (305) 287-5200, extension 200 or 246.

FAMILY PHYSICIAN to join thriving two doctor PA in booming Hallandale area. Salary and/or percentage first year. Contact: Snyderman/Drimmer, M.D., P. A., 2518 E. Hallandale Beach Boulevard, Hallandale, Florida 33009. Phone: (305) 921-7700.

FAMILY PRACTITIONER (AAFP qualified) wanted for north Florida college town. Busy practice in spacious, new two-man office building one half block from hospital. Enjoy getting out of the big city. Contact W. J. Bibb, M.D. (age 43), P.O. Box 179, Madison, Florida 32340. Phone: (904) 973-6561.

Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

MIAMI, FLORIDA AREA. Seven man multispecialty, fee-for-service group is seeking an internist to join the group. Generous first year profit guarantee. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

PEDIATRICIAN: Certified/eligible, U. S. citizen to join well established solo practice in Coral Gables, Florida. Salary and P. A. Benefits. Close to University facilities and children's hospital. Send curriculum vitae. Write C-648, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED/ELIGIBLE INTERNISTS, prefer recent sub-specialty training in rheumatology, nephrology, hematology, 26 MD multispecialty group. Also outstanding opportunity, board certified dermatologist for established practice. Reply to Administration, Palm Beach Medical Group, 705 North Olive Avenue, West Palm Beach, Florida 33401.

INTERNIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-619, P. O. Box 2411, Jacksonville, Florida 32203.

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OPHTHALMOLOGIST WANTED: Attractive opportunity in north central Florida. Community has well equipped, new 128-bed hospital and does not currently have an ophthalmologist. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

Miscellaneous

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Forty physician multispecialty group seeking internist-gastroenterologist, and GP. Affiliated general hospital just expanded to 308 beds. Clinic expansion completed May 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccousukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

FLORIDA COLLEGE HEALTH PHYSICIAN for urban university with Medical/Nursing School and excellent fringe benefits. Contact L. E. Steven, M.D., Director, University of South Florida, Student Health Services, Tampa, Florida 33620. Phone: (813) 974-2331.

FULL-TIME DIRECTOR OF PROFESSIONAL SERVICES experienced in community hospital affairs, to assume chief of staff leadership in managing, education, staff development, in 204-bed acute general hospital. Must have outstanding record of achievement in his field. Write C-640, P.O. Box 2411, Jacksonville, Florida 32203.

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EMERGENCY ROOM PHYSICIAN—FLORIDA CAPITAL CITY: to join other physicians in full E.R. coverage of 511-bed general hospital. 42 hour week, Florida license required. Beautiful location in university town, abundant fishing, water sports and hunting. Excellent schools, choice home sites. Minimum income of $40,000 with opportunity to increase. Contact Dr. George H. Evans, Chairman, Emergency Room Committee, Tallahassee Memorial Hospital, Tallahassee 32303.

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EMERGENCY ROOM, Ft. Walton Beach. New 230-bed, full service hospital plans to open in July 1974 with full time emergency department coverage. Seeking person to organize group practice and others to participate. Excellent opportunity on beautiful Gulf Coast. Contact General Hospital of Ft. Walton Beach, P.O. Drawer 1729, Ft. Walton Beach, Florida 32548. Phone (904) 242-1111.

EMERGENCY ROOM PHYSICIANS WANTED to join corporate group, $45,000 first year. Large modern emergency facility centrally located near Disney World and coast. Contact W. S. May Jr., M.D., 4511 Scottswood Dr., Lakeland, Florida 33803. Phone: (813) 646-6079.

PHYSICIAN DIRECTOR WANTED: General medical outpatient clinic. Progressive college community in central Florida. Excellent opportunity for the right person. Training in Family Practice or Internal Medicine preferred, Florida license required. Salary commensurate with training and experience. Contact: Raymond W. Wright, Administrator, Alachua General Hospital, Gainesville, Florida 32602; or call collect (904) 372-4321.

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Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

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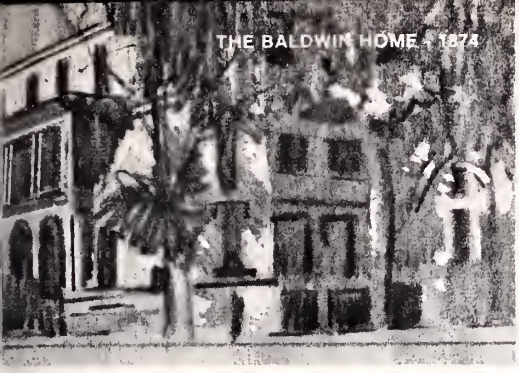

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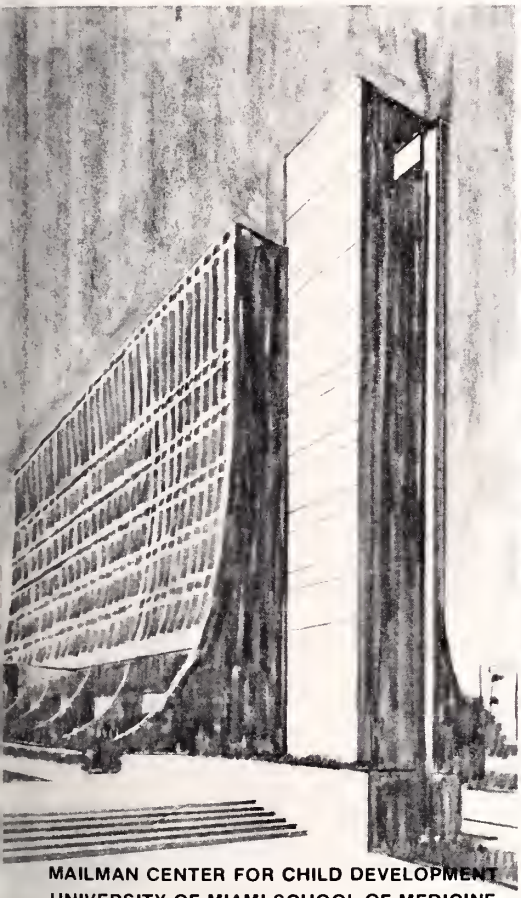

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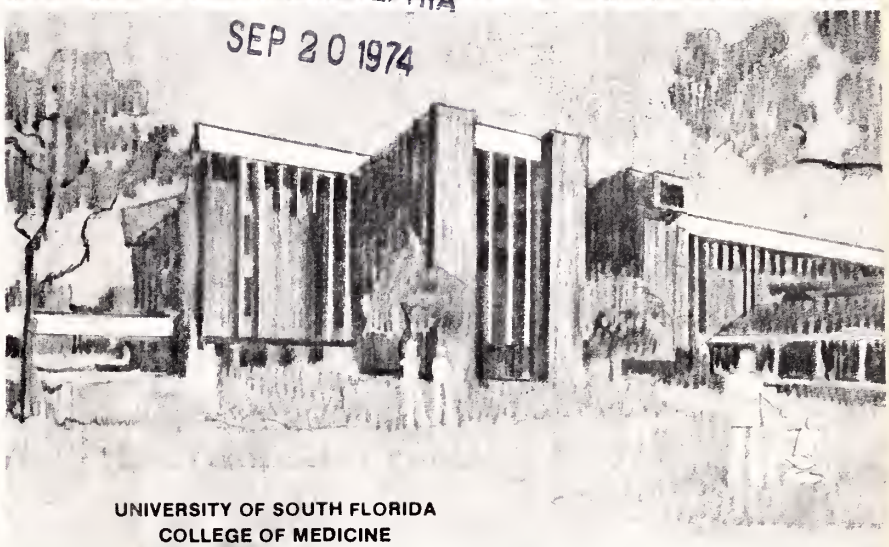

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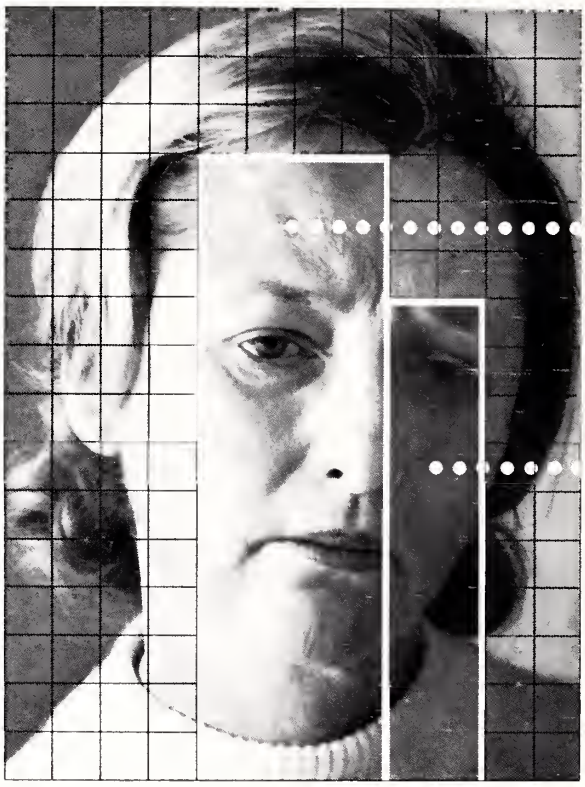

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Associated depressive symptoms

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard anti convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and mus cle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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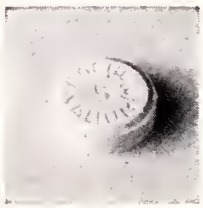
For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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President's Page

Peer Review

"We have a fine peer review system in Florida." Variations upon this declaration recurred throughout discussions of peer review during the 1974 Annual Meeting of the Florida Medical Association's House of Delegates.

Peer medical utilization review for Medicare patients constitutes the major portion of this review. It is conducted through Blue Shield, the fiscal agent, and carried out under contract between the Social Security Administration, Blue Shield and the Florida Medical Foundation.

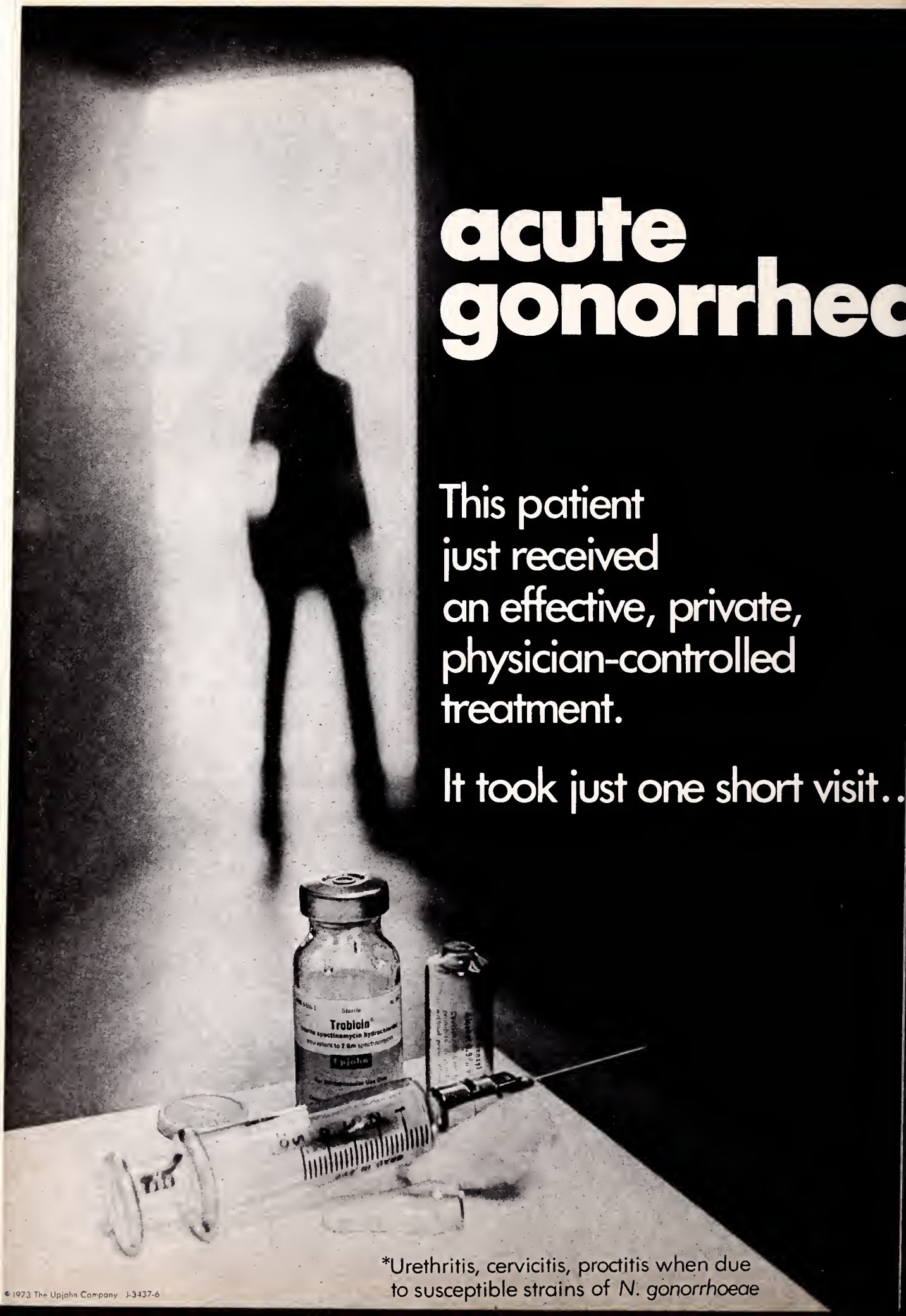
Since the House of Delegates meeting, I have conferred with Douglas M. Richard, regional representative of the Bureau of Health Insurance, Social Security Administration, Department of Health, Education, and Welfare; J. W. Herbert, president of Blue Cross-Blue Shield of Florida; and Dr. Joseph Matthews, chairman of the Blue Shield Board of Directors. I have met with the Blue Shield Board of Directors.

These contacts have provided a discouraging picture: review work due but not done; administrative assistance needed from FMA but not available; information necessary to complete patients' insurance not adequately supplied by physicians; physician manpower provided by Blue Shield inadequate for workload; court judgments questioning the review processes; review involving situations several years past.

The composite picture raises questions about the adequacy of our review processes. Efforts are under way to correct these deficiencies and to comply with the request of the House of Delegates that FMA have a superior peer review system. These efforts should bring peer review to the level of excellence of which we can be proud.

To survive in the present political arena, we must have an effective review system. More important, we owe our patients this evidence of concern for their care.

Thad Moseley


acute
gonorrhea
This patient
just received
an effective, private,
physician-controlled
treatment.
It took just one short visit..
Sterile
Trobicin
Upjohn
*Urethritis, cervicitis, proctitis when due
to susceptible strains of N. gonorrhoeae
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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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When the need is for nutritional supplementation with B complex and vitamin C, BEMINAL-500 has what it takes:

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- 500 mg. of vitamin C
- No odor
- No aftertaste

Each BEMINAL-500 tablet contains:

Thiamine mononitrate (Vit. B_1)	25.0 mg
Riboflavin (Vit. B_2)	12.5 mg
Niacinamide	100.0 mg
Pyridoxine hydrochloride (Vit. B_6)	10.0 mg
Calcium pantothenate	20.0 mg
Ascorbic acid (Vit. C) as sodium ascorbate	500.0 mg
Cyanocobalamin (Vit. B_{12})	5.0 mcg

Each tablet contains 0.15 mg. saccharin as sodium saccharin.

Each tablet provides the following multiples of the recognized adult minimum daily requirements:

Thiamine mononitrate	25
Riboflavin	10
Niacinamide	10
Ascorbic acid	16

The need for pyridoxine hydrochloride, calcium pantothenate, and cyanocobalamin in human nutrition has not been established.

USUAL DOSAGE: *Adults*—1 tablet daily, or as directed
SUPPLIED: No. 824—BEMINAL-500 Tablets, in bottles of 100

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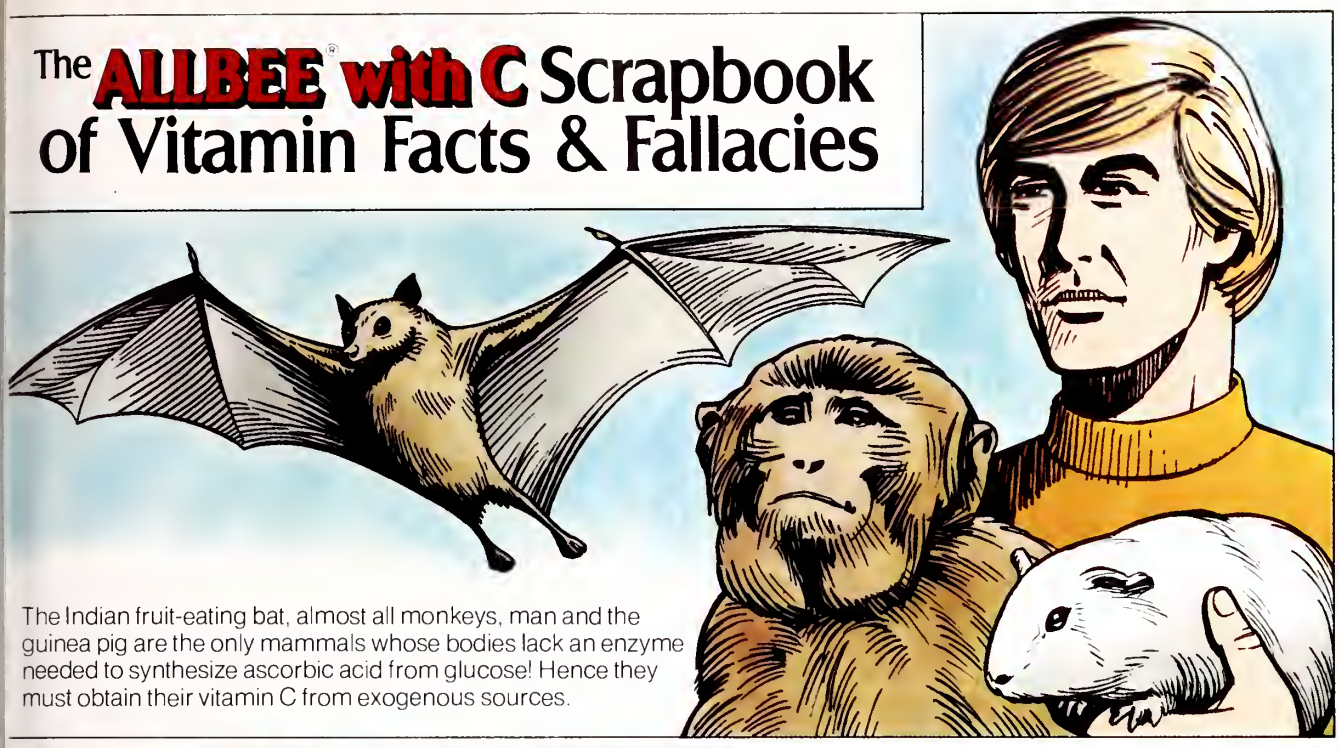
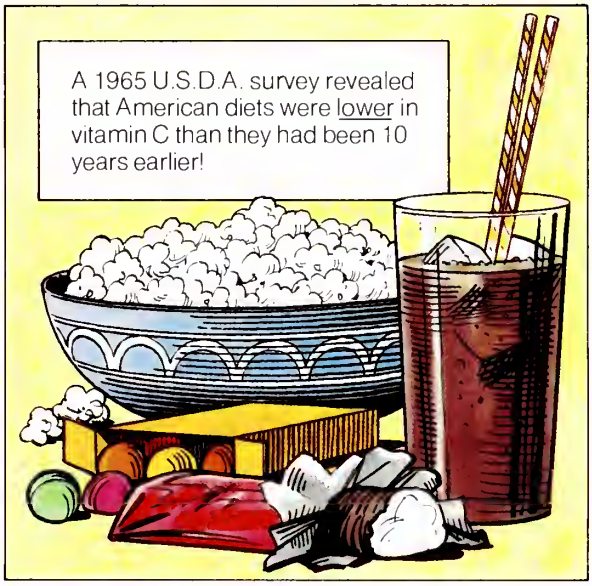
The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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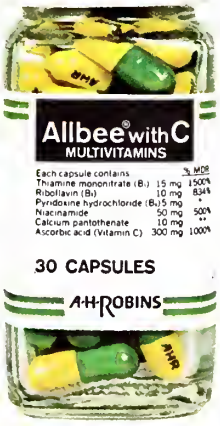
High Potency B-Complex and Vitamin C Formula



A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(warning: may be habit forming)			

Brief summary. Adverse Reactions: Blurring of vision, dry mouth difficult urination, and flushing or dryness of the skin may occur or higher dosage levels, rarely on usual dosage. Contraindications Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); o hypersensitivity to any of the ingredients.

A·H·ROBINS A. H. Robins Company. Richmond. Virginia 2322(

Dean's Page

Hospital Cost Containment

Chandler A. Stetson, M.D.

Along with other elements of the economy, hospitals were finally released earlier this year from federal controls which have failed to give us the "economic stabilization" that they were designed to produce. Now, after only a few months, the reimposition of economic controls on hospitals is being more and more openly discussed as a supposedly necessary feature of hospital "cost containment." No National Health Insurance bill can be passed, it is argued, until the Office of Management and Budget and the Congress are first satisfied that health care costs have been and would continue to be contained—memories of the events following passage of the Medicare legislation are evidently still embarrassing and painful, and they seem to have an understandable determination not to be burned twice.

Whatever the political and economic merits of this argument, there is no escaping the conclusion that this course of action would deal a severely damaging blow to hospitals and their capabilities to provide properly for patient care. Any real "cost containment," of course, ultimately reads out a curtailment of patient care in terms of restrictions of the range and/or quality of patient services. Hospitals cannot be placed selectively and artificially at a disadvantage in an inflationary economy without very quickly running into trouble, and facing the unpleasant alternatives of bankruptcy or of cheapening and restricting patient services.

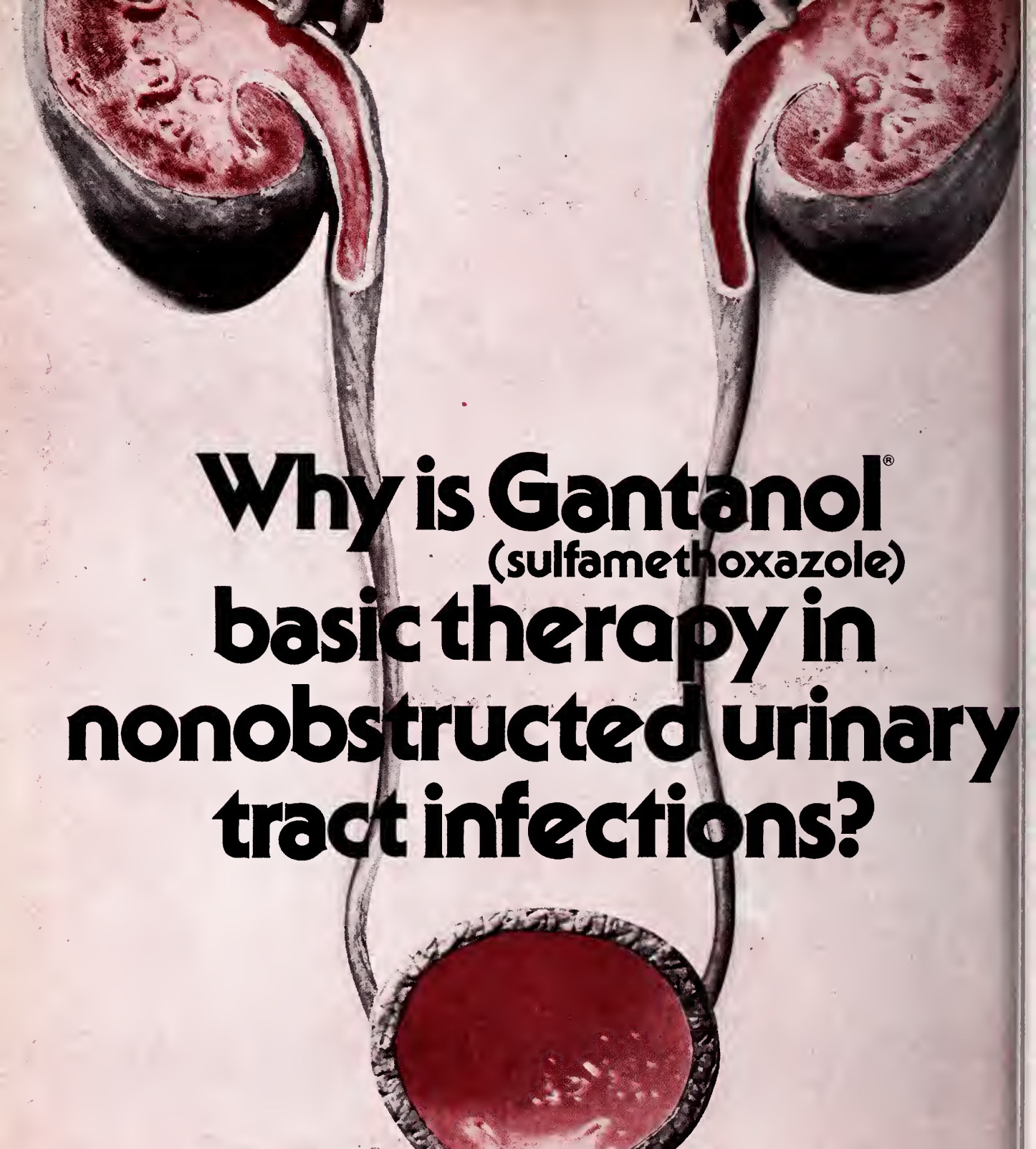
Hospital costs are as high as they are primarily because of labor-intensive nature of the industry. Large numbers of skilled people are necessary to operate a modern hospital, and this picture is not likely to change. Hospital managers have already sought cost-effectiveness in automation wherever they could, but this has been possible by and large only in the hospital's business offices, support services and clinical laboratories. Most of the things that must be done to and for patients have to be done by people, whose salaries have been ineluctably moving upwards, with equipment and supplies whose costs have also been high and going higher.

Another factor contributing to rising hospital costs has, of course, been the development of more and more sophisticated diagnostic and treatment facilities. Radiation therapy, cardiac catheterization, coronary care units are good examples of expensive but necessary elements of patient care, contributing indeed to the cost of the hospital but invaluable in their life-saving function.

While we should continue to make every effort to secure good, effective management for hospitals, and support every prudent step to keep cost within reasonable bounds, we must stand vigorously against moves which would threaten the quality of patient care. Good patient care is expensive to the individual and to society, and until the burden of disease is eased through preventive medicine and research it will continue to be costly. No amount of wishful thinking or bureaucratic meddling can change that, and we as physicians have a major responsibility to help the American people and their representatives to see the problem in this light.

▶ Dr. Stetson, University of Florida College of Medicine, Gainesville 32601.

Dr. Stetson is Dean, University of Florida College of Medicine, Gainesville.



Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
- for control of susceptible *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*
- for prompt antibacterial blood and urine levels in from 2 to 3 hours after initial 2-gram adult dose
- for economical around-the-clock coverage
- for maximum patient cooperation with easy-to-remember B.I.D. dosage

Basic Therapy

Gantanol®

(sulfamethoxazole)

Tablets/Suspension
(0.5 Gm) (0.5 Gm/teasp.)

pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

SEPT. 30, 1974

PROGRAM

Sept. 30 MONDAY

7:30 a.m. **REGISTRATION**
Read House

9:00 a.m. William H. Masters, M.D. Virginia E. Johnson, St. Louis, Mo., "SEX AND SEXUALITY"

10:00 a.m. **COFFEE BREAK**
Exhibit Visitation

10:30 a.m. Louis C. Lundstrom, General Motors Corp., Warren, Mich., "THE STATUS OF AUTO SAFETY" (GM ESV exhibit)

11:00 a.m. Joseph D. Godfrey, M.D., Buffalo, N.Y., "WHAT'S NEW IN SPORTS MEDICINE"?

1:00 p.m. **LUNCHEON**
Continental Room

SPEAKER:
Joseph D. Godfrey, M.D.
Team Physician, Buffalo Bills,
"CONTACT"

2:00 p.m. to 4:00 p.m. **SYMPOSIUM**

"SEXUAL DYSFUNCTION"

William H. Masters, M.D.
and
Virginia E. Johnson

Reproductive Biology Research Foundation
St. Louis, Mo.

(Symposium open to physicians, physician's wives and R.N.'s)

TENNESSEE VALLEY MEDICAL ASSEMBLY

THE READ HOUSE

CHATTANOOGA
TENNESSEE

Sept. 30 & Oct. 1, 1974

Wm. H. Masters, M.D.
St. Louis, Mo.

Wm. E. Thornton, M.D.
Houston, Texas

Virginia E. Johnson
St. Louis, Mo.

C. A. Harvey, M.D.
Groton, Conn.

Louis C. Lundstrom
Warren, Mich.

Peter C. Gazes, M.D.
Charleston, S.C.

Joseph D. Godfrey, M.D.
Buffalo, N.Y.

E. C. Wong, M.D.
Denver, Colo.

W. J. Lewis, M.D.
Dayton, Ohio

Arthur Taub, M.D.
New Haven, Conn.

OCT. 1, 1974

PROGRAM

Oct. 1 TUESDAY

8:00 a.m. **REGISTRATION**
Read House

9:00 a.m. Wm. E. Thornton, M.D., NASA, Houston, Tex., "WHAT'S NEW—SKYWARD"?

9:30 a.m. C. A. Harvey, M.D., Naval Submarine Med. Res. Lab., Groton, Conn., "PACKAGED ENVIRONMENTS—MAN'S PROGRESS IN SUB-AQUATIC SURVIVAL"

10:00 a.m. **COFFEE BREAK**
Exhibit Visitation

10:30 a.m. Peter C. Gazes, M.D., Charleston, S.C., "WHAT'S NEW IN MEDICAL OFFICE EMERGENCIES"?

11:00 a.m. E. C. Wong, Master Acupuncturist, Denver, Colo., "ACUPUNCTURE AS AN ADJUNCT"

11:30 a.m. Arthur Taub, M.D., Ph.D., New Haven, Conn., "ACUPUNCTURE—AN HISTORICAL ANALYSIS AND PHYSIOLOGICAL CRITIQUE"

1:00 p.m. **LUNCHEON**
Continental Room

SPEAKER:
W. J. Lewis, M.D., Chairman, AMPAC Board, Dayton, Ohio, "POLITICAL ACTION—AN EFFECTIVE LONG-RANGE PLAN"

2:00 p.m. to 4:00 p.m. **SYMPOSIUM**

"NEW MEDICAL HORIZONS IN SPACE AND UNDER THE SEA"

Wm. E. Thornton, M.D.
NASA, Houston, Texas

C. A. Harvey, M.D.
Naval Submarine Medical Research Laboratory, Groton, Connecticut

exhibits

T.V.M.A. 1974 proudly presents an attractive, informative and well programmed display of technical exhibits. The professional representatives who staff them are capable of furnishing background information on any products they have brought to the assembly. Plan to spend some time each day viewing the exhibits.

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

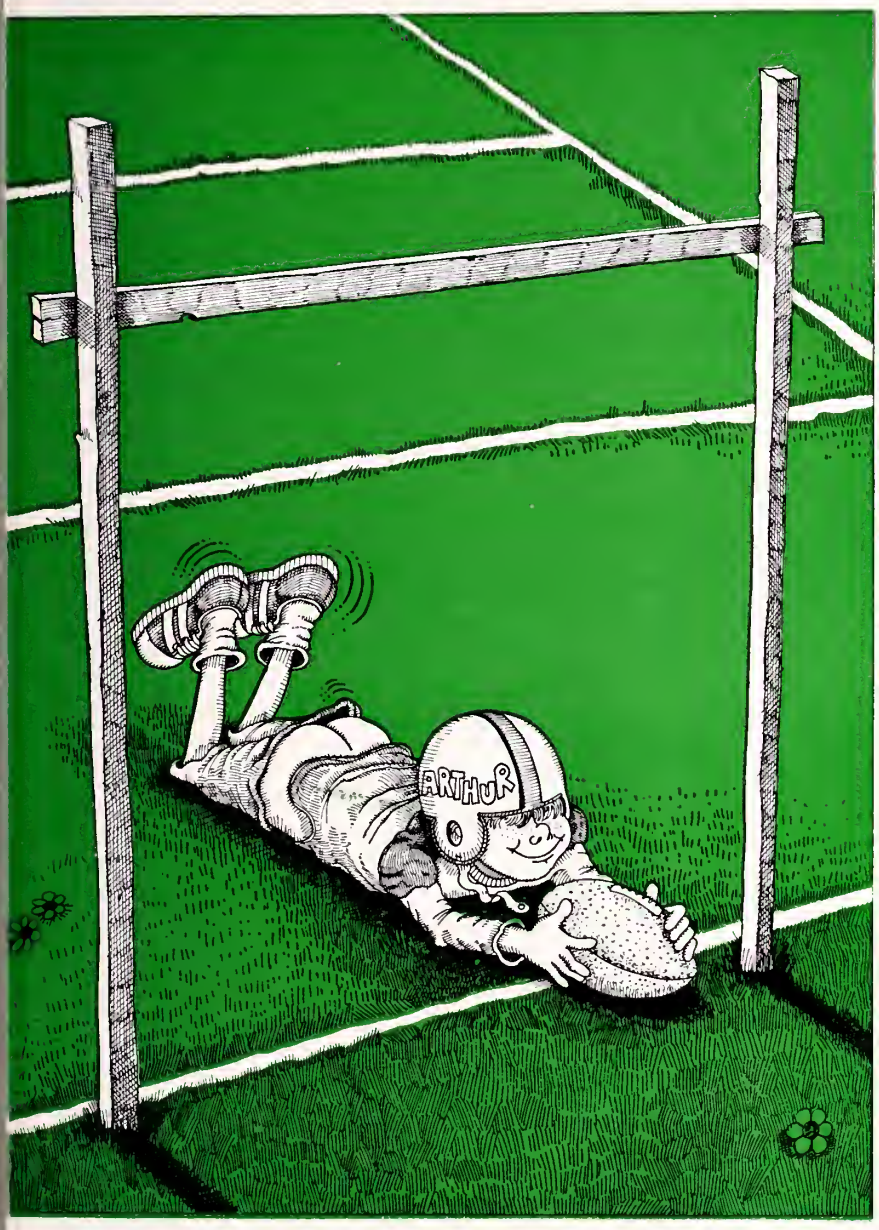
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

ata on file at Roerig.

Please see prescribing information on facing page.

DARVON®
COMPOUND-65
65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine
Darvocet-N® 100
100 mg. propoxyphene napsylate and 650 mg. acetaminophen
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Additional information available to the profession on request.
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

SEPTEMBER, 1974 • VOLUME 61 • NUMBER 9

Echocardiography

MAHFOUZ EL SHAHAWY, M.D. AND LAMAR CREVASSE, M.D.

Abstract: This brief review is meant to acquaint the physician with recent advances in the use of echocardiography, which might be one of the most significant achievements in cardiology within the past 20 years. The vigorous and impressive studies done with echocardiography over the last few years, have demonstrated the usefulness of this technique.

Its applications in cardiology are quite extensive and expanding at a rapid pace. Today there are certain cardiac lesions which one can diagnose with certainty by echocardiography and those which can be excluded or support a clinical impression.

For example, echocardiography can be helpful in the diagnosis of congenital cardiac lesions, valvular disease, cardiomyopathy, pericardial effusion, intracardiac tumor, estimation of the dimension of the heart chamber sizes, and estimation of left ventricular function.

This brief review is meant to acquaint the physician with recent advances in the use of echocardiography, which might be one of the most significant achievements in cardiology within the past 20 years.

The term "echocardiography" implies the technique where the pulsed reflected ultrasound is utilized to visualize the heart in a noninvasive manner. This was first introduced into cardiology in 1954 by Edler and Hertz in Sweden.[1] The use of ultrasound, however, for detection of underwater objects has been known to the Navy for many years under the term "sonar."

The vigorous and impressive studies done with echocardiography over the last few years particularly by Joyner and Feigenbaum in this country have demonstrated the usefulness of this technique.[2-4]

Principles and Techniques

The instrumentation used in cardiac diagnosis employs high frequency, approximately 2 megahertz low intensity sounds. This behaves like light at the interface of two media with different acoustic impedance. A portion of the energy is reflected, some of it returning as an echo to its source, the remaining portion is available to produce echos at other interfaces.[5-7] The reflected echos are displayed on an oscilloscope and recorded on a Polaroid camera or a strip chart recorder in correct relationship to the actual distances in soft tissue.

Where and how is this technique performed? It can be performed any place since the machine is easily transportable (Fig. 1). The examination is usually performed with the patient in the recumbent position, however varying the position of the patient might sometimes be necessary.[8] The transducer is placed along the left sternal border approximately at the 3rd or 4th intercostal space. In this way one can sweep with ultrasonic beam from the apex to the base of the heart or vice versa, identifying the various structures according to the angulation one makes with the transducer.[9] This noninvasive, atraumatic bedside examination obviously has many ad-

Dr. El Shahawy is Assistant Professor of Medicine and Dr. Crevasse is Professor of Medicine in the Division of Cardiology of the Department of Medicine, University of Florida College of Medicine, Gainesville.

Fig. 1.—Echocardiographic machine currently in use in our laboratory.

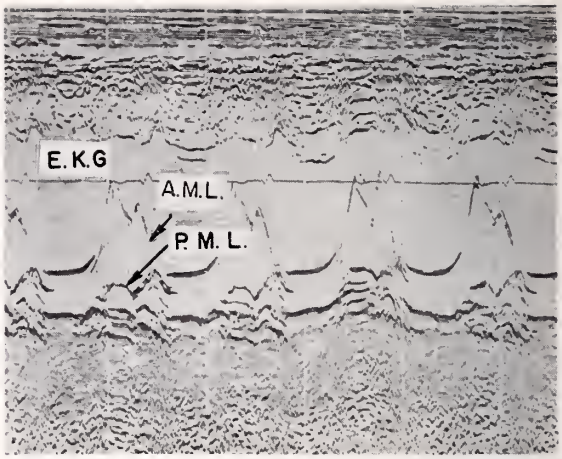
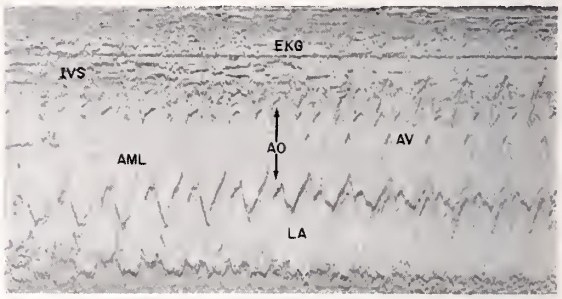
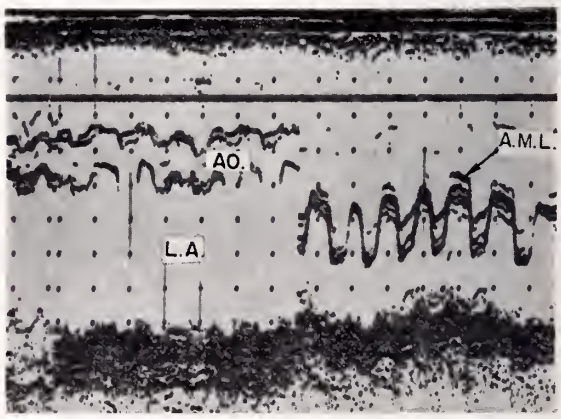


Fig. 2.—a. Normal mitral valve echo—note the anterior (AML) and posterior (PML) mitral leaflets meeting together in systole forming one single line; also note that the PML normally is a mirror image of AML.



b. Echogram demonstrating a sweep from the mitral valve (AML) to the aortic root (AO) in a young healthy student. Note the space behind the aorta (AO) representing the left atrium (LA) is about the same size as the aorta. Also note the aortic valve (AV) between the anterior and posterior wall of the aorta.



c. Echogram from a patient with severe calcific mitral stenosis.
Note (1) both anterior and posterior leaflets are moving in the same direction. (2) the slope of the AML is markedly diminished; also the leaflets echos are heavy. (3) the left atrium (LA) is markedly dilated as contrasted with the aorta (AO).

TABLE 1.—ADVANTAGES OF ECHOCARDIOGRAPHY.

1. Noninvasive procedure
2. Detection of minor tissue differences and soft tissue structures
3. Recording of cardiac movements
4. No immediate or late harmful effects

TABLE 2.—CONGENITAL LESIONS.

A. DIAGNOSTIC:
Single ventricle, Ebstein anomalie, tetralogy of Fallot, transposition of the great arteries, double outlet right ventricle, truncus arteriosus, and idiopathic hypertrophic subaortic stenosis

B. RULE OUT:
Atrial septal defect, anomalous pulmonary venous return, ventricular septal defect

TABLE 3.—ACQUIRED LESIONS.

Mitral valve: Mitral stenosis, prolapse (M.R.)—mitral regurgitation

Aortic valve: Aortic stenosis, aortic insufficiency

Cardiomyopathy: Primarily or ischemic?

Pericardiac effusion

Intracardiac tumors

Possible if suitably located: Aneurysm, thrombos, akinetic or hypokinetic segments

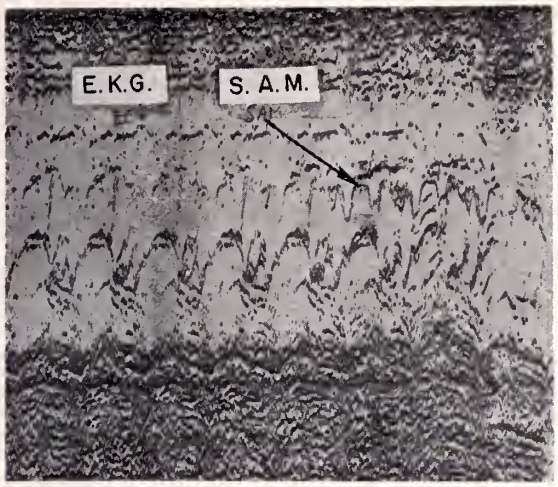


Fig. 3.—Echogram from a patient with idiopathic hypertrophic subaortic stenosis (IHSS) with a resting gradient of 70 mm Hg found at the time of cardiac catheterization. Note: the abnormal motion of the anterior mitral leaflet during systole, where it touches the interventricular septum (S.A.M.).

vantages, as noted in Table 1, which makes this procedure very attractive as contrasted with many other conventional cardiologic examinations, particularly in patients who are quite ill.

Applications in Cardiology

Its applications are quite extensive and expanding at a rapid pace.[9] Today there are certain cardiac lesions which one can diagnose with certainty by echocardiography and those which can be excluded or support a clinical impression.

In Table 2 are some of the congenital conditions which can be diagnosed by echocardiography (Group A)[10-15] and those which can reasonably be ruled out or support a clinical impression (Group B).[16-17]

In Table 3 are a number of acquired cardiac lesions which can be diagnosed with the echocardiogram.[18-25] The most diagnostic echos one might see, for example, are in patients with mitral stenosis (Figs. 2a-c); not only qualitative but quantitative information can be gained by this technique. Other important conditions diagnosed by this technique are patients with prolapsing mitral leaflet, idiopathic hypertrophic subaortic stenosis (Fig. 3) and aortic incompetence (Fig. 4). The detection of pericardial effusion with echocardiography (Figs. 5a-b) probably has provided the greatest impetus to echocardiography technique in this country.[24]

The use of echocardiography for detection of intracardiac tumors and particularly left atrial myxomas has been very rewarding.[25] In addition,

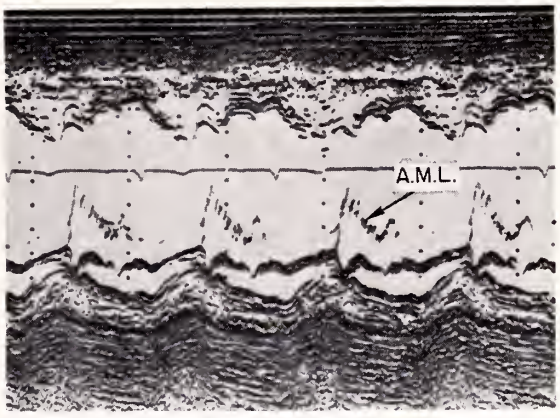


Fig. 4.—Mitral valve echogram from 18-year-old boy with incompetent aortic valve secondary to bacterial endocarditis. Note the flutter wave on the anterior leaflet of the mitral valve (AML), which is thought to be diagnostic for the presence of aortic insufficiency.

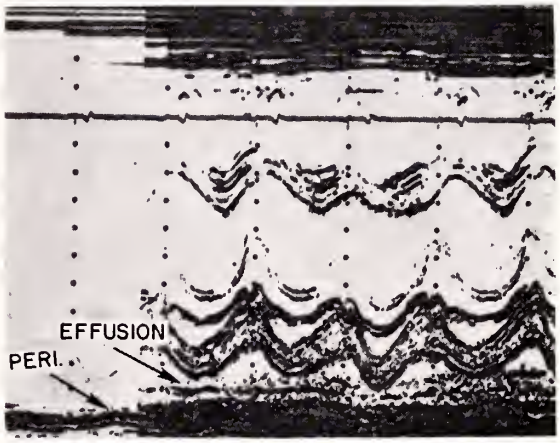
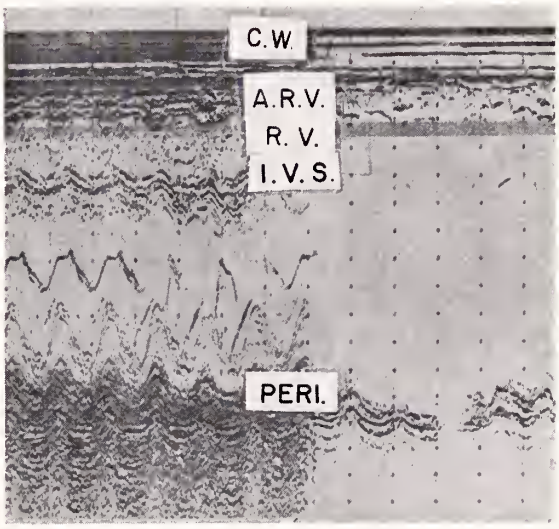


Fig. 5.—a. Echogram from a patient with pericardiac effusion. Note echo free space between pericardium (peri) and epicardium.



b. Echogram from the same patient (in 5a) after pericardiac tap. Note the disappearance of the space between the pericardium (peri) and epicardium.

CW = anterior chest wall
ARV = anterior right ventricular wall
RV = right ventricular cavity
IVS = inter-ventricular septum

Table 4.—Echocardiography Can Be Helpful in the Diagnosis of:

1. Congenital cardiac lesions
2. Valvular disease
3. Cardiomyopathies
4. Pericardial effusion
5. Intracardiac tumor
6. Estimation of the dimension of the heart chamber sizes
7. Estimation of left ventricular function

the ability of echocardiography to obtain such quantitative measurements of the left ventricular function in a noninvasive manner has caused much excitement and enthusiasm for that technique over the last few years.[9] There are still numerous applications in which echocardiography might be helpful such as estimation of the dimension of the heart chamber sizes,[26] post-op follow-up of mitral valve commissurotomies or detection of ball variance.[27] Finally, echocardiography is used in conjunction with other graphic procedures such as phono and pulse tracing to expand our knowledge for understanding of heart sound and murmurs.[28]

In spite of the most impressive expansion of echocardiography over the last few years, we are still in a phase of rapid development of this technique. This technique is convenient and noninvasive as far as the patient is concerned, but demands meticulous technical proficiency by the examiner. Experience is required for transducer placement, direction of ultrasonic beam, control setting and interpretation.

In conclusion, echocardiography can be helpful today in the recording of abnormalities of anatomy and motion which may be found in several cardiac disorders as noted on Table 4. In the near future, its applications will be expanded and areas other than cardiology further defined.

References are available from the authors upon request.

▶ Dr. El Shahawy, Department of Medicine, University of Florida College of Medicine, Gainesville 32610.

Important Notice to Authors

Beginning with the January 1975 issue, *The Journal of the Florida Medical Association* will begin a gradual conversion from the United States Customary to the Metric System of Weights and Measures.

In all manuscripts published in 1975, weights and measures will be quoted in both terms with the metric figure used first and the U.S. Customary equivalent following in parentheses. Example:

. . . an incision 10.16 cm. (four inches) long . . .

Beginning with the January 1976 issue, all weights and measures will be quoted only in metric terms.

It will be the responsibility of each author to see to it that his manuscript contains the proper metric measurements.

The Committee on Scientific Publications will be grateful for the cooperation of all authors.

Clyde M. Collins, M.D.
Editor

Salmonella Typhosa Urinary Tract Infection and Xanthogranulomatous Pyelonephritis

Case Report and Review of Literature

Stephen Machiz, M.D., Julian Gordon, M.D., Norman Block, M.D., and Victor A. Politano, M.D.

Abstract: Salmonella typhosa is commonly associated with gastrointestinal symptoms, fever and malaise but may involve the urinary tract. Such a case is presented. Salmonella typhosa was found in both stool and urine, and intravenous pyelogram revealed nonvisualization and calculi of the right kidney. Although salmonella was eradicated from the gastrointestinal tract the urine remained infected. At exploration calculous pyonephrosis and xanthogranulomatous pyelonephritis were found. Six months postoperatively the patient's urine and stool cultures remain free of pathogens. This case is presented to draw attention to the fact that a salmonella urinary carrier state can occur following a systemic salmonella infection although the gastrointestinal pathology has been eradicated. Underlying renal disease may cause the kidney to become a chronic focus of infection and must be carefully followed. Nephrectomy or correction of the underlying abnormality must be considered in antibiotic-resistant cases.

The typhoid epidemic in February 1973 at a South Dade labor camp was well publicized. This paper describes an unusual case of a woman who presented with Salmonella typhosa and was found to have renal calculi, a nonvisualizing right kidney on intravenous pyelogram, and a persistent salmonella urinary tract infection.

Case Report

A 67-year-old black female was admitted to Jackson Memorial Hospital in August 1972 for evaluation of a four-week history of low back pain, anorexia, nausea, vomiting, low grade fever and a nine pound weight loss. She denied any change in bowel habits or irritative bladder symptoms. Past history, family history and social history were all unremarkable and there was no history of exposure to typhoid. The source of her infection is unknown.

Physical examination was normal except for a nontender, slightly mobile 8-10 cm right flank mass. The hemoglobin on admission was 10 grams per cent and the WBC 7,300. Urinalysis showed profuse white blood cells and occasional red blood cells. The blood urea nitrogen, creatinine, sugar and sickle cell prep were normal. Liver function studies were normal. A stool culture revealed Salmonella typhosa and a urine culture Salmonella group D, Entero coccus, and E. coli. A chest x-ray revealed an elevated right hemidiaphragm and discoid atelectasis. An oral cholecystogram, upper gastrointestinal series and barium enema were all normal. Intravenous urography revealed a nonfunctioning right kidney containing multiple renal calculi (Fig. 1). Retrograde pyelography showed a right ureteropelvic junction obstruction. Arteriography demonstrated attenuated and displaced vessels on the right, consistent with chronic inflammation. The diagnosis of xanthogranulomatous pyelonephritis was considered (Fig. 2).

Intravenous ampicillin was begun but the low grade febrile course (99-101° F.) continued. Because of the persistent fever, obstructive uropathy and urinary tract infection, the patient was taken to surgery. A large, yellow-appearing kidney adherent to the duodenum colon, and liver was found and a nephrectomy was performed.

Pathologic examination revealed xanthogranulomatous pyelonephritis, calculous pyonephrosis, and marked perinephritis. Purulent material aspirated from the kidney at surgery grew out salmonella typhosa. Urine and stool cultures at six months following surgery were negative for salmonella. (Figs. 3a, 3b).

Discussion

Salmonella typhosa infection involving the kidney has been described by many authors over the past 50 years.[1-6] The organism can be isolated from the blood in 90-95% of patients with typhoid fever by the second to fifth days of the disease. It is by this route that the organism may reach the kidney. The bacillus appears in the urine in 20-40% of cases during the second to third week of the illness.[4,6] Chronic urinary carriers of salmonella have been identified and defined as those who excrete salmonella for more than one year. Dreyfuss in a review of 24,500 cases of typhoid fever in the literature found 0.2% to 3.3% to be urinary carriers.[5]

From the Department of Urology, University of Miami School of Medicine, Miami

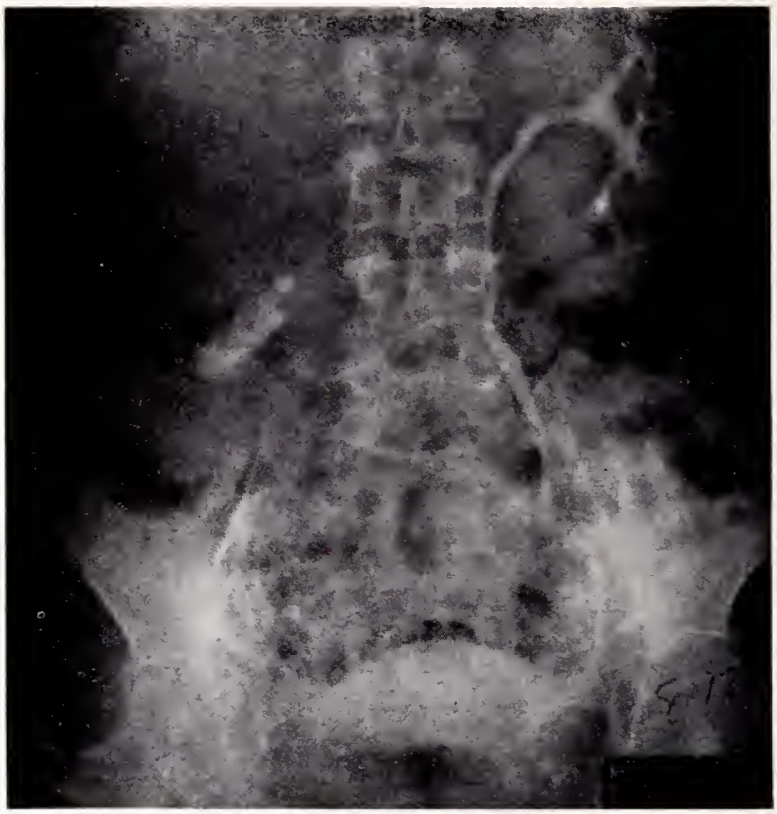


Fig. 1.—Intravenous urogram shows a normal left kidney and a non-visualizing right kidney with overlying calcific densities.

Fig. 2.—Selective right renal arteriogram demonstrates attenuated and displaced vessels.

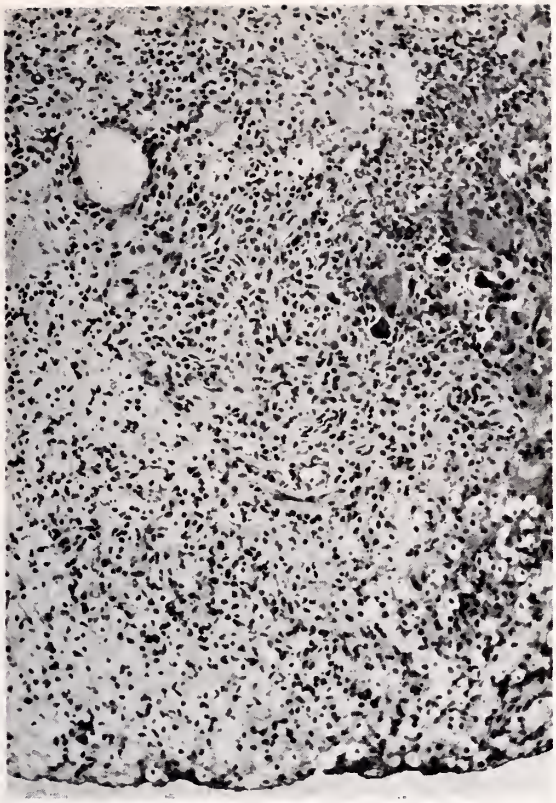


Fig. 3a.—Shows typical foam cells and giant cells of xanthogranulomatous pyelonephritis (H & E, X 154).

Fig. 3b.—Lower power view from same tissue block showing renal pelvis, renal tubules and glomeruli infiltrated with inflammatory cells (H & E x 49).

Salmonella bacteriuria may occasionally be noted without an obvious underlying pathologic abnormality; generally, underlying disease is present and should be identified. Predisposing etiologies include chronic pyelonephritis, congenital abnormalities, preexisting calculi, obstruction and/or stasis from any cause.

Obstruction and replacement with fibrosis and fat produce an entity which can mimic abscess, pyonephrosis, or tumor. Anhalt et al reviewed 90 cases and found nonfunctioning kidney in 80% and calculi in 70%.[7] Proteus was cultured from the urine in 60% of the patients and E. coli in another 30%. The patients generally presented with flank pain, fever, and weight loss. Xanthogranulomatous pyelonephritis in combination with urinary salmonellosis is quite unusual. Either entity may produce a difficult diagnostic picture.

A case of typhoid fever, xanthogranulomatous pyelonephritis and salmonella pyonephrosis is presented. Urologic evaluation and subsequent nephrectomy were required. The association of systemic salmonella typhosa infection and urinary tract involvement is discussed with emphasis on the recognition of the chronic urinary carrier.

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▶ Dr. Block, Department of Urology, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami 33152.

If God had believed in permissiveness, He would have given us The Ten Suggestions.

Letters

Medicaid

Dear Doctor Kiehl: Thank you so much for your letter of May 6th that was reproduced in our July Journal pointing out the very unpopular federal regulation requiring the doctor to take patients on assignment in the Medicaid Program. Almost all of the improvements in our State's program have been the direct result of recommendations made to the Division of Family Services by FMA's Ad Hoc Committee on Medicaid and all changes actively seek the blessings of organized medicine. I personally see no reason why this federal regulation cannot be changed, too, if it is the wish of the practicing physician.

I am not clever enough to be "slippery" and the program was instituted long before I appeared on the scene with the expressed purpose of making Medicaid more doctor-oriented. Without adequate representation of medicine in government the public through their political representatives all too often are forced to make medical care decisions without adequate guidance and "medical care" implies personal attention and service to me.

At times my work seems almost ineffectual as I try to integrate the medical needs of our aged and disabled that are poor with the realities of this program, but most often I am actually caught up with the great purpose involved and I am able to withstand the criticism and vituperation that is apparently inherent in such a position better in the knowledge that I am not a member of the staff but a medical consultant with many years of practice behind me to better serve you and our community of doctors.

With kindest personal regards and the sincere hope of meeting you personally in the near future, I am

Most sincerely yours,

Matthew E. Morrow, M.D.
State Medical Consultant
Bureau of Medical Services

Retirement

To the Editor: In February 1965, you published in The Journal of Florida Medical Association an article, "History and Development of the Association of Retired Doctors of Medicine of Broward County, Florida, Inc.," by Dr. Earl Rice and myself.

I am enclosing a manuscript, "Contentment in Retirement for the Physician," for your consideration. This article represents more or less the fruits of our experience as retired physicians. At present we have a membership of 130 retired doctors of medicine, all of Broward County.

As a member and one of the founders of our Association, I believe there are sufficient senior medical men in Florida who might enjoy sharing in our efforts and accomplishments.

Thanking you for your consideration,

Frederick P. Moersch, M.D.
Fort Lauderdale

See page 715 for article, "Contentment in Retirement for the Physician."

Editor's Note: Under the heading CLINITRIX will appear useful bits of information or tricks of the trade which do not lend themselves to classical presentation. Please send us yours.

Clinitrix

Problem: Take a history from a deaf patient. Trick: Put your stethescope in the ears of the patient, then speak into the chest piece. I don't remember when or how this started. I have been doing it since very early in residency.

John Turner, M.D.
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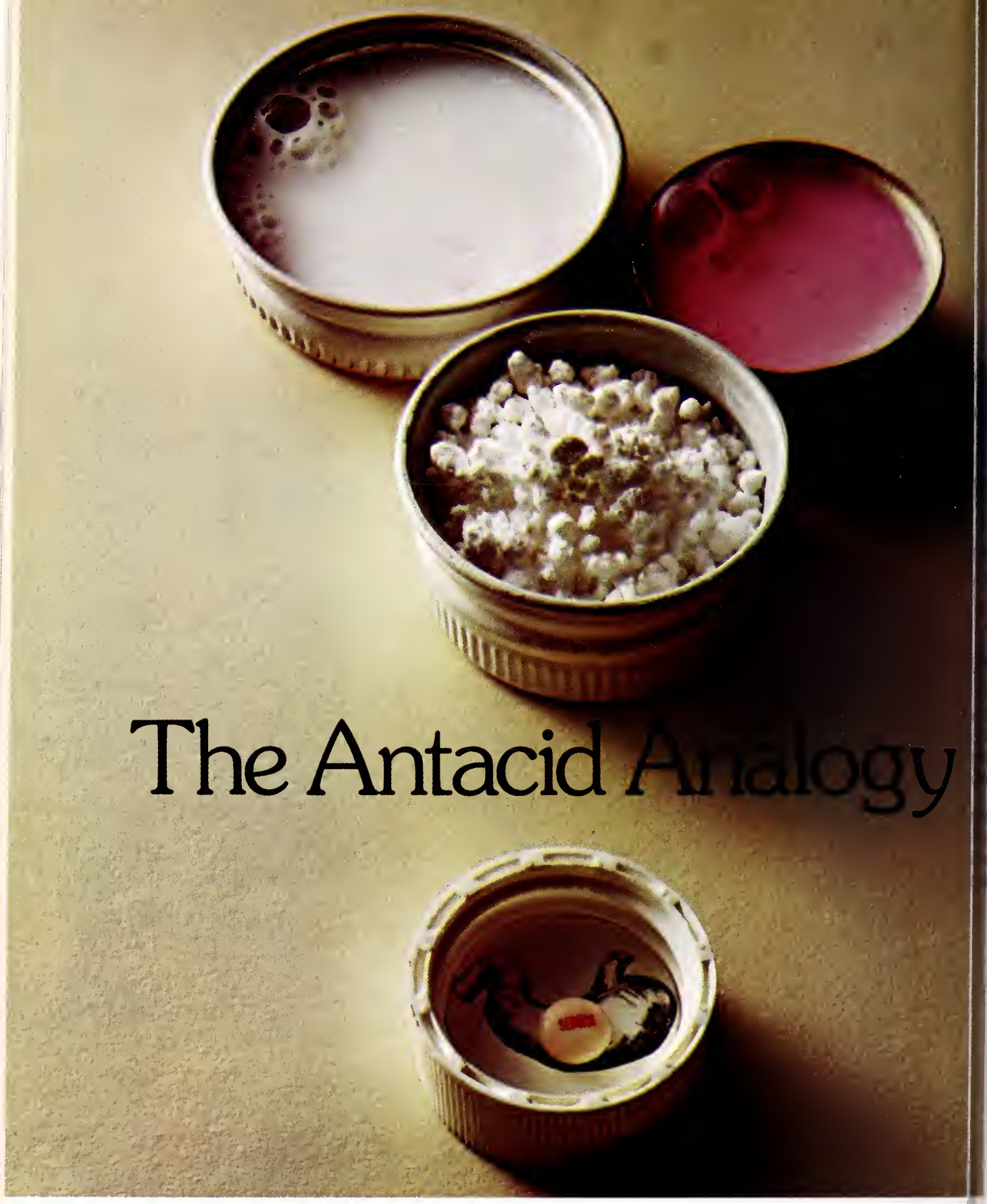

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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cur as well as mydriasis and blurred vision. In addition the following verse reactions have been reported: nervousness, drowsiness, dizziness, omnia, headache, loss of the sense of taste, nausea, vomiting, constipa- n, impotence and allergic dermatitis.

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The Role of the Detail Man

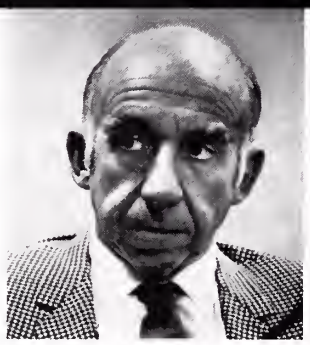
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail mer I meet. Most of them are knowledge able about the drugs they promote and can be a great help in acquaint- ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the na- ture of my practice. They, there- fore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this countr there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representa- tives and salesmen of the pharma- ceutical industry is the type of con- tact that people in a medical center research people, and academic people have and that's in all likelihc on a somewhat different level from that of the practicing physician.

Let me touch on how I person- ally perceive the role of the sales representative. These men reach large numbers of health profes- sionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real edu- cational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientific- ally sound and therefore truly use- ful—as well as some excellent film produced by the pharmaceutical industry. When they function in thi

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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P·M·A

Special Articles

The Baker Act Can Work

Richard E. Gordon, M.D., Ph.D., George W. Barnard, M.D.,
Robert H. Gervais, M.D., David P. Snyder, M.N., and James P. Dale, M.Div.

Abstract: This report on 20 months of experience with Tricounty Area patients presents evidence on the potential impact of the Baker Act on Florida's population. Most mental patients in the district are now being treated successfully in their homes and communities and being kept out of hospitals. When hospitalization is required, its duration is being reduced to a minimum and usually requires only the services of the receiving facility hospital. A decreasing number of patients require long term care. When they do and are sent to the state hospital, the majority do not remain there long, with the result that the Tricounty census in the regional hospital declines steadily.

This brief report describes data obtained on inpatients treated under the Baker Act from the Tricounty Area (Flagler, Putnam and St. Johns) District 7 in Florida. This area, with a population of nearly 77,000 persons, represents approximately 1% of the state's population.

In an effort to reduce the occurrence, severity, duration and disabling aspects of mental, emotional and behavioral disorders, the Baker Act offers intensive, short-term care for psychiatric patients in need of inpatient services. Receiving facility hospitals in each district can provide up to 15 days of this care. Patients requiring longer periods of treatment are transferred to the regional state hospital. The remainder are returned home to be followed up in a community mental health or other service. The system is designed to encourage patients not to become dependent on the hospital but to assume responsibility for their treatment and recovery. This philosophy is diametrically opposed to the traditional one which, in essence, provided sanctuaries to which the mentally ill could retreat. Now each district is expected to care for its own citizens as close to home as possible, and not to send them off to distant hospitals far from their families and jobs.

Method

Patients first began to receive care under provisions of the Baker Act in July 1972. In the Tricounty Area only minimal unstructured outpatient services were available at that time through the county health departments. The Community Mental Health Clinic outpatient services in the district opened a year later on July 1, 1973.

Data were collected on the number of patients admitted under the Baker Act from the Tricounty Area to the Shands Teaching and Flagler Hospitals, which are the receiving facility hospitals for the district. The number of patient treatment days was also recorded from the Shands Teaching Hospital. Statistics were obtained from the Division of Mental Health on the number of admissions from 1969 through January 1974 from the Tricounty Area to the state hospital system and its regional hospital, Northeast Florida State Hospital, as well as from the state as a whole to the entire state hospital system. Data were also obtained on the number of Tricounty residents each year in the total state hospital system, and at the regional state hospital, as well as on all residents in the total state hospital system.

Results

The findings of this study are shown in Tables 1 and 2. Table 1 presents the state hospital data on admissions and on residents from the Tricounty Area, comparing them to similar information on patients from the whole state. The striking drop

From the Department of Psychiatry, University of Florida College of Medicine, Gainesville, and the Tricounty Mental Health Center, Palatka.

in the numbers of admissions from the Tricounty Area after the Baker Act went into effect—from 92 down to 42—is very apparent. This 54.4% decrease is especially significant because the total number of admissions to the state hospitals as a whole rose 4.6% during the same period. It is possible that this figure may drop still further since some patients bypass the screening process in the receiving hospitals by going directly to the state hospital.

Even more striking results are found by looking at the number of Tricounty residents in all the state hospitals, and particularly those at the regional state hospital in Macclenny, and comparing both of these to the figures of the total number of residents in state hospitals for the state as a whole. Tricounty patients residing at the regional hospital dropped 45% from 49 in July 1972 to 27 a year later. Since July 1973 the Tricounty resident census at Northeast Florida State Hospital has continued to decrease, and by March 1, 1974 it had plummeted to 12 persons. In the rest of the state system Tricounty residents decreased 23.7% from 118 to 90. (Most of these patients are older persons who have been hospitalized for many years at the Florida State Hospital at Chattahoochee. They, too, benefit from the provisions of the Baker Act but not so quickly as do new admissions who still have ties to their homes, families and communities).

In contrast to these data from the Tricounty Area, the number of resident patients for the state as a whole declined 16% from 1972-73 when the Baker Act went into effect. This, too, represents an improvement since in prior years the number of resident patients from the entire state in all its hospitals had been decreasing by about 9% per annum (Table 1).

Data from the Shands Teaching Hospital and Flagler Hospital inpatient psychiatric units are shown in Table 2. In the first six months of operation under the Baker Act, when the community first became acquainted with the services, only 47 patients were admitted. In the next six months, however, when minimal outpatient services were available for treatment and screening, the number of admissions rose to 125. Upon the opening of the Mental Health Clinic outpatient facilities in the Tricounty Area in July 1973, Tricounty admissions under the Baker Act to the impatient unit at Shands Teaching Hospital and the newly opened Flagler Hospital Psychiatric Unit dropped to 94. At present inpatient figures are still declining and have reached an estimated level of 75 admissions every six months. Data on patient days closely parallel the number of admissions to the Shands Teaching Hospital.

Comment

It appears that the goals of the Baker Act are being met in the Tricounty Area, as well as in the rest of the state to a lesser extent. The underlying philosophy is for each area to provide community based mental health care for as many patients as possible. Although after only 20 months of experience the final data are not in, it appears that the psychiatric patient population in Florida's state hospitals is being reduced, both the total number of patient residents in the state and in the Tricounty District also in the number of admissions.

Table 1.—Tricounty Psychiatric Patients Admitted or Resident in Florida State Hospitals.

Number of Admissions	7/69-6/70	7/70-6/71	7/71-6/72	Baker Act in Effect	7/72-6/73	7/73-6/74 (Projected)
Tricounty to all Florida Hospitals	94	86	92		42	(50)
Total in State Hospitals	4803	5217	5472		5726	(6650)
Number of Residents						
Tricounty in NEFSH	52	49	49		27	12
Tricounty in other State Hospitals	160	147	118		90	—
TOTAL IN STATE	9272	8873	8170		6578	

Patients were admitted from the Tricounty Area under the auspices of the Baker Act to the receiving facility inpatient unit in July 1972 as shown by the vertical line. The projected figures are based on data for July to December 1973. NEFSH refers to the regional state hospital serving the Tricounty District—Northeast Florida State Hospital at Macclenny.

Table 2.—Tricounty Psychiatric Patients Admitted to Receiving Facility Hospital Inpatient Units.

Number of Admissions	7/72-12/72	1/73-6/73	Community Mental Health Clinic	7/73-12/73	1/74-6/74 (Projected)
Shands Teaching and Flagler Hospitals	47	125		97	(75)
Number of Patient Days Shands Teaching Hospital	523	1365		1132	(762)

The Community Mental Health clinics in the Tricounty District opened in July 1973 a shown by tbe vertical line. The projected figures are based on data for January and February 1974.

In the first year that the ward at the Shands Teaching Hospital was opened to Baker Act patients, a large number of unscreened patients was admitted. Once outpatient screening and clinical facilities became available to persons in acute crisis, however, the inpatient census at the receiving facility went down. Most crises are now managed as outpatients in the clinic. The inpatient units of the receiving facility, in turn, which screen out patients who need long-term care from those who can be managed in two weeks or less, worked effectively in reducing the number of patients referred to the state hospital system.

Patients arriving at the regional state hospital, furthermore, need not remain long. Most patients sent to the state hospital from the receiving facility hospital were no longer acutely ill—they had already begun treatment. As shown by the enormous decrease in the Tricounty Area patient census at the Northeast Florida State Hospital, they can be discharged back to their homes more quickly than ever before.

Many former patients, who otherwise would have returned periodically to the state hospitals, have begun to receive medical, psychosocial and other services at the community mental health clinics. This follow-up on ex-patients is helping them live more normal lives and reducing their need for rehospitalization.

Summary

This report on 20 months experience with Tricounty Area patients presents evidence on the potential impact of the Baker Act on Florida's population. Most mental patients in the district are now being treated successfully in their homes and communities and being kept out of hospitals. When hospitalization is required, its duration is being reduced to a minimum and usually requires only the services of the receiving facility hospital. A decreasing number of patients require long-term care. When they do and are sent to the state hospital, the majority do not remain there long, with the result that the Tricounty census in the regional hospital is declining steadily. Looking at the whole picture, we can see a total system in operation: the clinic provides the first line of treatment in the community; its receiving facility hospital backs it up; the state hospital is needed for long-term care; and finally, in turn, the comprehensive mental health clinic takes care of the patients discharged from the state and receiving facility hospitals. When all parts of the system effectively relate to, and cooperate with each other, patients gain maximum benefit.

In the Tricounty Area the Baker Act patients were essentially under the care of mental health personnel operating in the public sector of the economy. We believe that in other counties where the private sector is also involved even better results can be obtained, although time will be needed to work out the complicated interrelationships.

The authors appreciate the assistance of Ms. Judy Brundyge of the Division of Mental Health, Ms. Sheila Donaldson of the Department of Psychiatry at Shands Teaching Hospital, and Mrs. Tonnie Blakely of Northeast Florida State Hospital.

▶ Dr. Gordon, Department of Psychiatry, University of Florida College of Medicine, Gainesville 32610.

Those who love deeply never grow old; they may die of old age, but they die young.
—Arthur Wing Pinero

Medicaid's Nursing Home Program

Matthew E. Morrow, M.D.

September, that time of year "when yellow leaves, or none, or few, do hang upon the bough" seems an appropriate time to examine, even if rather sketchily, the nursing home program. To cover this gigantic problem in this limited space is well nigh impossible, but to make a beginning let's recognize the fact that of approximately 25,000 nursing home beds in Florida about 70% of them are occupied by Medicaid recipients. Now this alone seems strange to me when you realize that of this state's 8 million residents only about 4 hundred thousand are eligible for Medicaid (and many of these are children).

Does this obvious inequity exist because the average self-supporting portion of our population just can't afford nursing home care? Is it because they have families to care for their old folks at home? Is it because the government can afford for the poor what the average citizen can't afford for himself? Or is it because the welfare state is attempting to solve a social problem for the aged-poor by passing it off as a medical problem?

There is much written these days about the cupidity, complicity, and neglect in our country's nursing homes, but I can assure you there are many fine nursing homes in Florida. If there is a great waste of the state's money in most of them the blame has to be placed on our present system of determining need for nursing home care and more specifically in deciding the level of care required. Hopefully, by the time this editorial is published a more definitive medical system will be in operation.

At last report 86% of the Medicaid patients in Florida's nursing homes were said to require skilled nursing care ($550/month) while none of the 22 states represented in last winter's meeting of Medicaid directors had over 10% of their nursing home population designated as such. I have personally heard a well-known administrator of a nursing home say he could make any patient qualify for skilled nursing home care (pay) while another one told me he was penalized (got less money) if he "allowed" his patients to improve. But don't be too shocked, I know of one nursing home patient that waited breathlessly for eleven days to be pronounced dead by her physician.

Somehow it doesn't seem quite cricket to me for the practicing physician who owns all or part of a nursing home to be able to designate that his patient should be classified as skilled when he sends them to "his" nursing home. Nor does it seem quite cricket to me for a nursing home to accept all of a patient's worldly possessions as full payment for perpetual care and thereby make him eligible for Medicaid and its vendor payments. Robert E. Burger, in an article in the Saturday Review, has gone so far as to say that "in the life-care contract the resentment of a guest who is 'overdue' cannot fail to have its effect."

Gerontologists generally agree that the most dangerous treatment for the senile is inactivity and though confinement to bed lessens the staff's work it is the beginning of the end for the elderly. Certainly, if any rehabilitation for these people is to be done it must be done elsewhere or before they are actually admitted to a nursing home. Day care centers for the elderly reportedly are solving some of this problem.

Well, what is the answer? There are many alternatives but here are some thoughts. Reserve nursing home beds for only those people who can pay for them as a luxury and those that actually need the daily care of a registered nurse or physiotherapist. Put licensure and inspection under one team. At the present time nursing homes are frequently inspected ad nauseam by at least a dozen different groups. Establish health care facilities (Note: I said Health Care *not* Medical Care) for the aged that cannot care for themselves to be run by the County Health Departments. Allow as many old people as possible to remain happily in their own homes—no matter how humble or small or blessedly dirty they might be and mobilize their medical and health care instead of them.

There is much more to be done if we are to adequately provide for our state's elderly and there are many additions to the few suggestions made in the preceding paragraph, but I believe by working with them we could save the taxpayers at least a third of the 60 million dollars our state now appropriates for indigent care in our nursing homes while greatly benefitting our elderly poor.

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Here in the sky, I lie.
Here in the sky, I sigh.
Here in the sky, I die.
In my coffin in the sky.

Buried in the sky I lie
Counting the days until I die.
Wishing I could but touch the earth
Or feel the wind or hear a sound
Or see Spring's magic all around.

"If only I had planned better for this day.
I could have made my exit in another way."

Buried in the sky, I sigh
Ever so lightly, oh my,
Lest some one hear me and come quick
With a shot or a pill or even worse
Something to keep me from disturbing the nurse.

"Now you must be nice, Mr. Jones"—she'd say.
And this injection will keep you that way—all day."

Buried in the sky, I die
In my coffin in the sky
Encased in concrete, steel, and glass
Removed from everything I ever knew
Staring endlessly into the blue.

"Is there anything more that I can possibly say
To help you plan for your final day."

Here in the sky, I lie.
Here in the sky, I sigh.
Here in the sky, I die.
In my coffin in the sky.

▶ Dr. Morrow, State Medical Consultant, Division of Family Services, Jacksonville

Author's note: I am aware that my poetry is not so good and admittedly a bit corny, but again I'm trying to say as much as possible in short order.

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A "Letter to the Editor" may help you get something off your mind that others in Florida would like to know about. We have a place for it in your *Journal*.

Contentment in Retirement for the Physician

Frederick P. Moersch, M.D.

Retirement for the physician should bring with it a benediction for work well done; surely the labors of the past merit contentment during the sunset years of his life.

In February 1965, we reported in *The Journal of the Florida Medical Association,* the formation of the Association of Retired Doctors of Medicine of Broward County, Inc. in 1959. Our theme was to see if contentment could be achieved in the great challenge occurring with retirement.

Approximately 10% of all retired American medical men live in Florida. According to the American Medical Association 2,484 inactive physicians were living in Florida as of December 1973. Of this group, 440 were residing in Broward County. The inactive category as stated by the American Medical Association consists of retired, semi-retired, permanently disabled, temporarily not in active practice and not active for other reasons; the majority of the inactive group are retired physicians. At this writing our association has 130 members.

We are of the opinion that the great majority of our members are content in their retirement and pleased to be associated with our organization; there does exist a degree of concern due to our lack of recognition and inability to partake in medical activities.

As medical men we recognize the many problems that accompany the abandonment of active practice. Today, many physicians, regardless of their ability, are subject to mandatory retirement at the age of 65 years. The impact of withdrawing from the active stream of life may be more fully appreciated if we realize that at this writing more than 20 million, or 10%, of all Americans are 65 years of age or older. As has been well stated, "Old age remains an unexplored frontier of human experience."

As the scene changes to that of retirement the medical man, as all senior citizens, should envisage a panorama spreading over 10 to 15 years of enjoyable activities. It may be observed that the portals of contentment in abandoning one's practice are manifold. Frequently with the withdrawal from active service the physician will embark on a world cruise; the adventure may be so enticing that another vagabond is born, and the entire world becomes his playground.

Probably one of the most rewarding pursuits for a physically able retiree is gardening. He who has a love for nature will find that gardening serves as a great aid to obtaining peace. As I wrote some years ago, "Of all hobbies, gardening is one of the simplest, most satisfying and salutary. Nature has a way of beckoning us, but its simplicity may fail to impress us in our hasty and superficial search for happiness. The very simplicity of gardening is one of its chief assets." The venture in gardening may range from a grass plot and a few geraniums to an avocation capturing the individual's entire attention. Additional activities available to the retiree are endless.

The physician who retires in his home community will find a world of work in which he may share as little or as much as he chooses. In our association most of our members are from other states and have no Florida license to practice medicine. Many of these members would gladly do some part time medical work, which as yet has not been made available to them.

Medical men should be especially able to adjust to the waning years of their lives. We have learned from our colleagues that age in itself is no barrier to the learning process. The retired doctor as all senior citizens should increase his circle of friends. Indeed, as stated by Samuel Johnson, "If a man does not make new acquaintances as he advances through life, he will soon find himself left alone. A man, Sir, should keep his friendship in constant repair." It is well to bear in mind that our ill or ailing colleagues are in need of comaraderie. Finally, it may be said that happiness will be the reward of diligent effort. It is not so much which path is chosen but how one treads that path.

Epilogue

Our theme has been contentment during the rapidly vanishing sunset years that fall upon all of us. The vast assembly of retired American citizens form an endless procession, marching to that

mysterious goal where all men are found to be equal. As physicians we should look upon this period in our lives as a great challenge in an interesting adventure. With the proper attitude, with courage and wisdom, happiness can be achieved. If we heed the motto, "To serve and not be served," we can accept the adage of Marcus Aurelius, "Very little is needed to make a happy life. It is all within yourself, in your way of thinking."

There is no single path to successful retirement. Indeed, there are many avenues open to the traveler. While the ways may differ one from the other, they can all be equally rewarding. Our hope is to enrich the sunset years of retirement. As the seasons pass we offer a quiet requiem for the contentment and the degree of accomplishment that has been ours. The traveler chooses the course to follow and follows it with the will to live and to live well.

▶ Dr. Moersch, 2718 N. E. 10th Street, Fort Lauderdale 33305.

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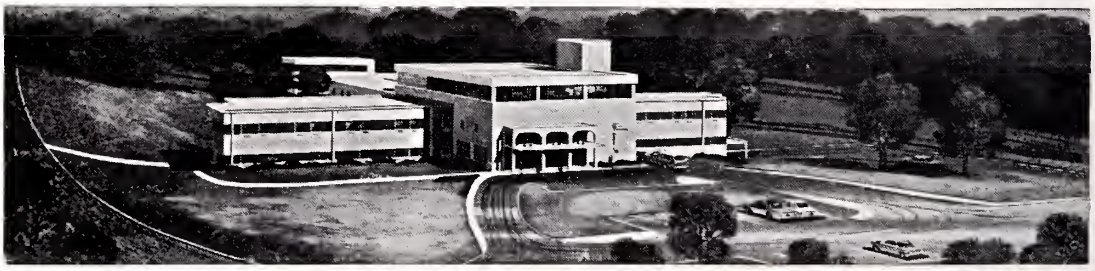

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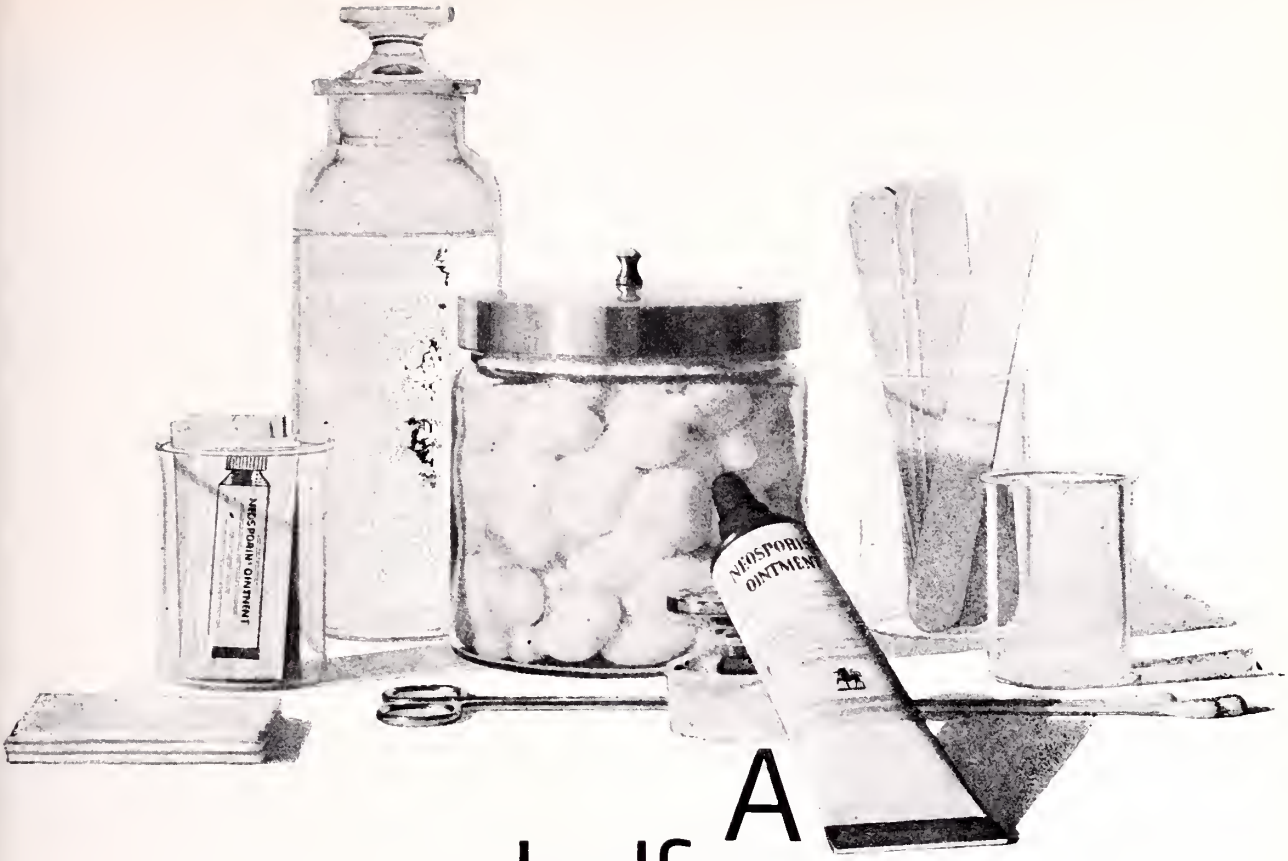

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Editorial

A Period of Austerity

"Greatly begin! though thou have time
But for a line, be that sublime—
Not failure, but low aim, is crime."
James Russell Lowell

Take an ordinary physician who has the love of wonder, truth, good literature, beauty, art, photography, medicine, his fellow physicians, and a hankering to do his part in the activities of organized medicine. Give him the job of editing the local organization's publication with a dedicated staff to assist him, then let him get printer's ink in his veins, and soon you'll find that fellow full of aspirations to mail out each month a production incorporating ideas such as those used to attract readers to Newsweek, the Wall Street Journal, the New England Journal of Medicine, and the Bible. With an unlimited budget, this probably could be successfully attempted, but in this era of inflation, as the economy of the nation has gone, so has gone the economy of the Florida Medical Association, and a period of austerity is before us.

In the face of constantly rising costs of paper, printing, postage and engraving, beginning with the Centennial issue in January, followed by a costly issue each month, the fat Proceedings issue and the customary historical one in August, each monthly accounting statement this year has ended in red ink. As each month's Journal begins to take shape the problem is, how to tailor the material so as to pay for publishing it from advertising. In spite of the editorial staff's perseverance to produce an outstanding Journal in the face of hindrances, discouragements and unpredictable revenue from pharmaceutical advertising, it is apparent that *The Journal* must cut costs, eliminate all trivia and frills and publish only that original material which will allow it to stay within its budget.

As "poverty is no disgrace to acknowledge, yet a real degradation to make no effort to overcome" and, as the present financial crisis has been a recurring plight confronting each editor since Dr. Henley put out the first issue in 1914, this is not a time when the present editorial staff will be content with a drab second rate Journal, but will do everything to maintain standards of excellence. Along with additional advertising revenue anticipated through statewide solicitation, with possible use of newer methods of automated publication and with the resurgence of national drug advertising, as has always occurred in the past, *The Journal* will regain its size, and publish as much of everything submitted as possible. So, until the return of budgetary prosperity, beginning with this issue, *The Journal* will publish only that which can be supported from advertising, yet never failing to continue to assert and maintain its purpose as the communication arm of the Florida Medical Association.

C.M.C.

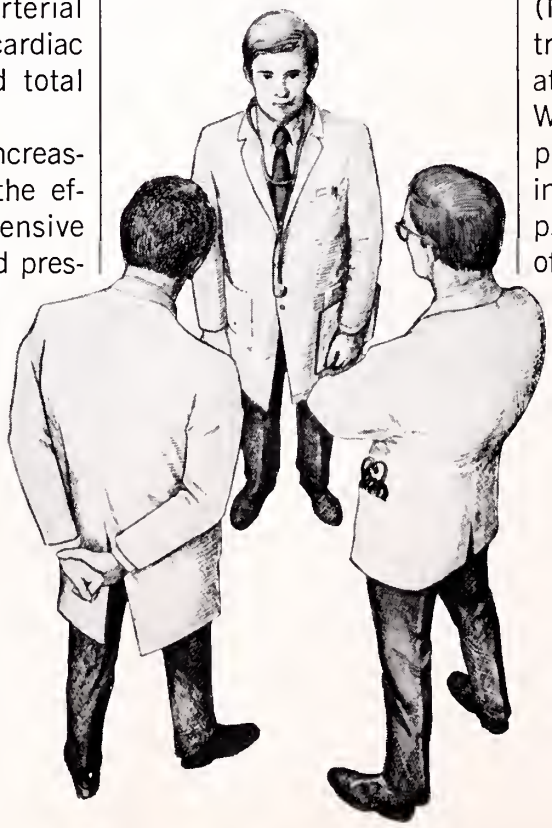
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

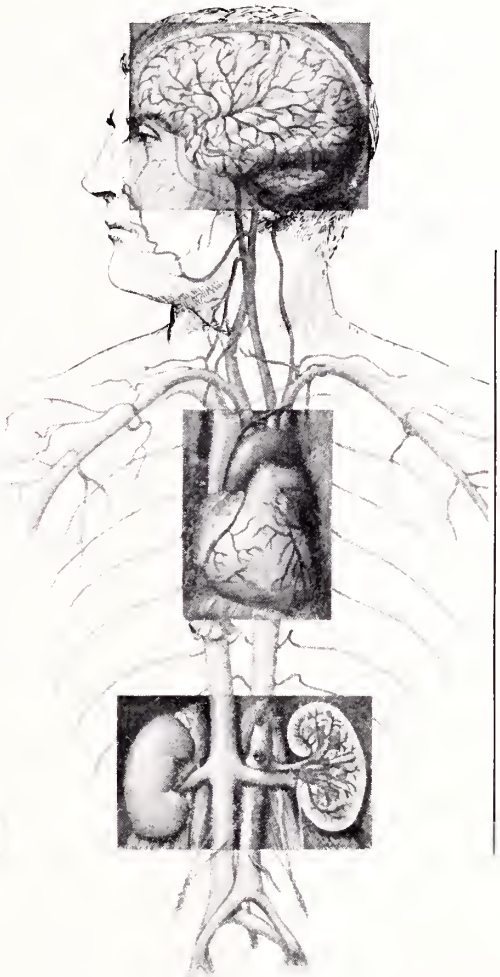
With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive

lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.



Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in 500 mg TABLETS as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

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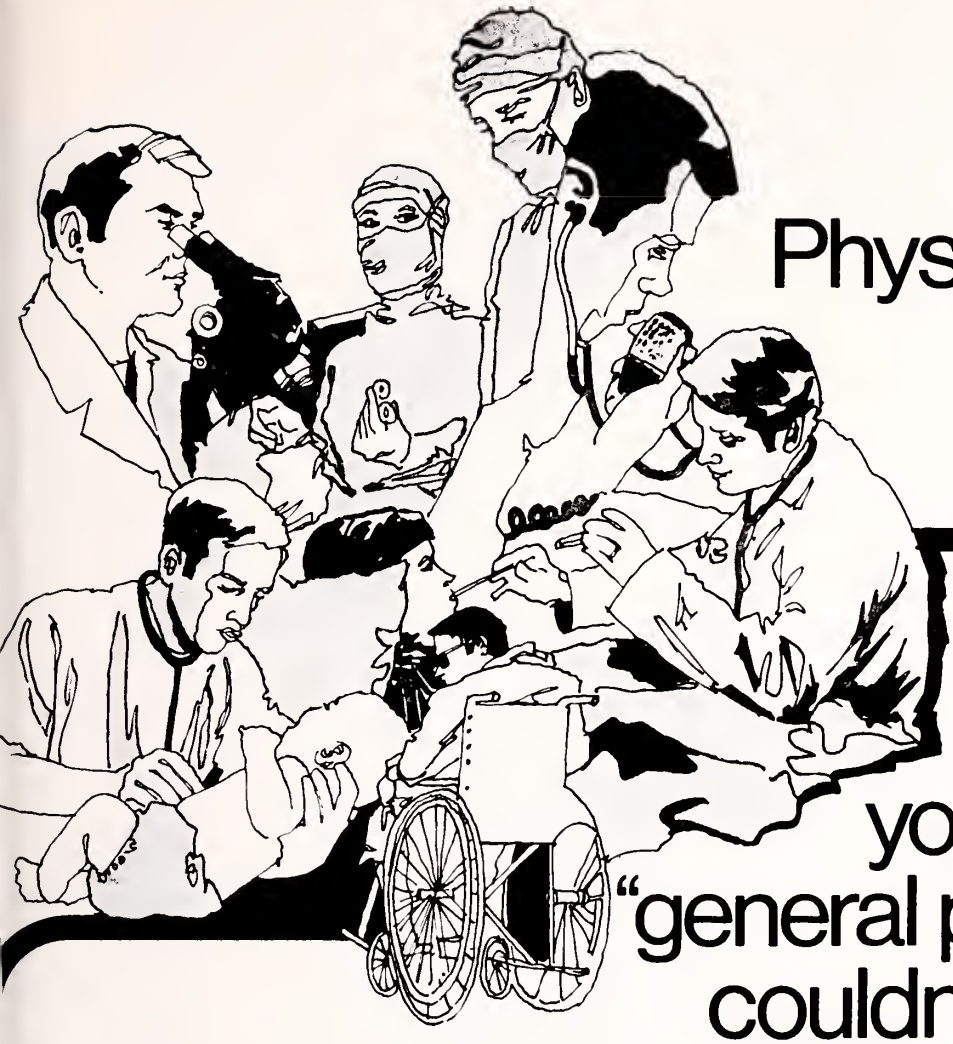
"Required Reading" For Your Hypertensive Patients

Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.



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Air Force Medicine

Deaths

Bluestone, Alexander H., Hollywood; born 1919; Middlesex Medical School, 1944; member AMA; died February 26, 1974.

Blum, Henry, Miami Beach; born 1897; Bellevue Hospital Medical School, 1920; member AMA; died January 17, 1974.

Cooper, Leonard S., Sarasota; born 1917; Jefferson Medical School, 1943; member AMA; died April 30, 1974.

Courreges, Frank R., Jacksonville; born 1940; Louisiana State University, 1967; member AMA; died January 6, 1974.

Galloway, Dolph V., Daytona Beach; born 1901; Tennessee Medical School, 1925; member AMA; died January 28, 1974.

Hill, James A., Jacksonville; born 1929; University of North Carolina, 1955; member AMA; died February 3, 1974.

Hutchison, William C., Miami; born 1904; University of Pittsburgh, 1927; member AMA; died May 29, 1974.

Johnson, Charles A. Jr., Clearwater; born 1921; Emory University, 1944; member AMA; died April 29, 1974.

Kushner, Daniel S., Miami Beach; born 1922; Pennsylvania Medical School, 1946; member AMA; died January 16, 1974.

McKenzie, George E., Miami; born 1898; University of Pittsburgh, 1922; member AMA; died April 5, 1974.

Page, Woodfin G., Orlando; born 1890; Vanderbilt University, 1915; member AMA; died June 26, 1974.

Pyle, Frank J., Orlando; born 1900; University of Pittsburgh, 1931; member AMA; died March 31, 1974.

Smith, Ballard F., Fort Lauderdale; born 1921; University of Buffalo, 1946; member AMA; died April 17, 1974.

Stathis, Anthony L., Bradenton; born 1924; University of Miami, 1959; member AMA; died March 19, 1974.

Tyre, Chambers M., Eustis; born 1890; Atlanta School of Medicine, 1911; member AMA; died April 8, 1974.

Warden, Cyrus E., Melbourne; born 1906; Columbia University, 1932; member AMA; died January 31, 1974.

Zimmerman, Maurice, Miami Beach; born 1897; New York Medical College, 1922; member AMA; died May 25, 1974.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

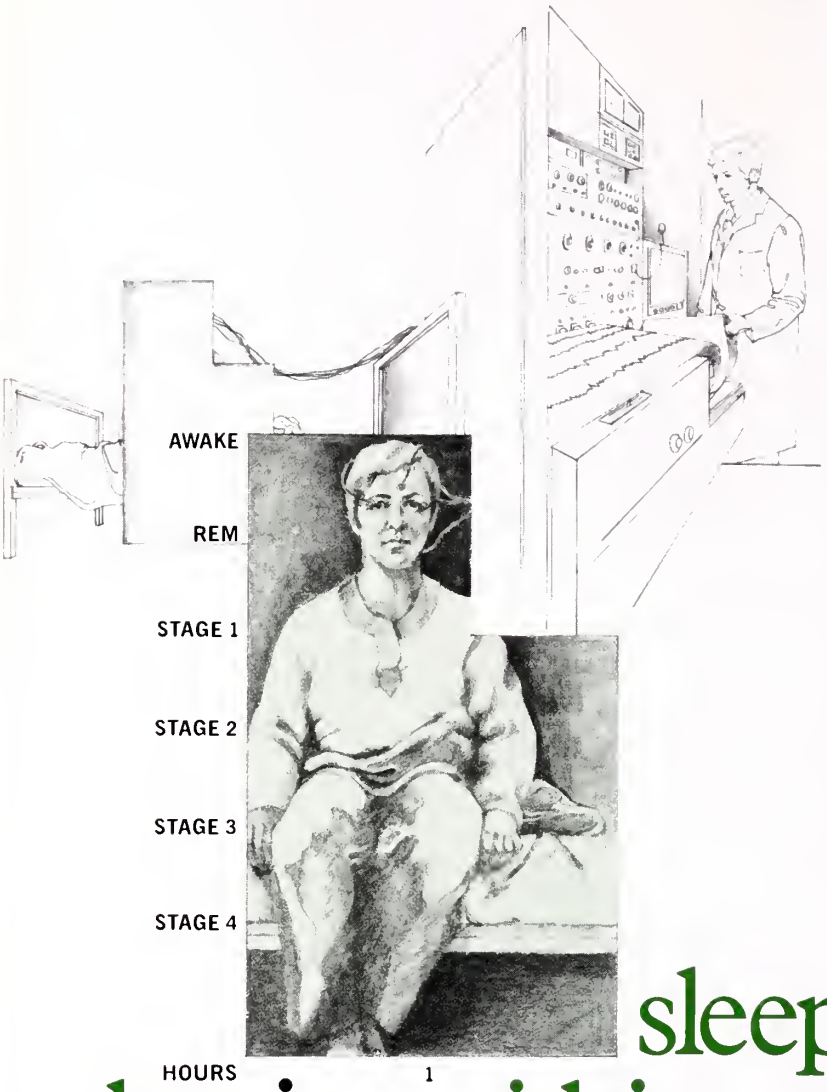
Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

tudies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains are known to be resistant, routine sensitivity testing is recommended.



sleep begins within 17 minutes, on average ...

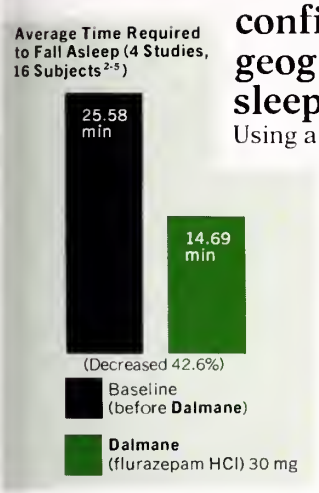
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

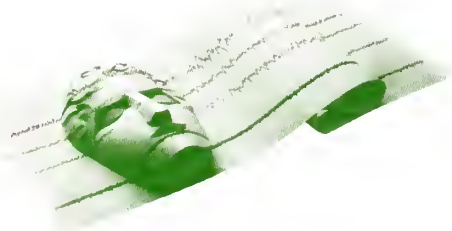
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Neither man nor the gorilla can synthesize vitamin C. Interestingly, the slow loris, a primate much further down the evolutionary scale, can convert L-1,4-gulonolactone to ascorbic acid in its liver and presumably does not require an exogenous source of ascorbic acid.

Because man can neither synthesize vitamin C nor store most of the water soluble vitamins, these nutrients must be replenished continuously in order to maintain normal tissue levels.

Generally, this is accomplished in his daily diet. But under conditions of illness, stress, in convalescence or following surgery, vitamin stores may be depleted or metabolic demands increased.

In such cases, Surbex-T may be indicated. Surbex-T restores the water-soluble vitamins with each tablet providing 500 mg. of vitamin C plus high potency B-complex.

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Restores what the body cannot effectively store

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Rheumatoid Factors

RICHARD S. PANUSH, M.D.

Abstract: An appreciation of rheumatoid factors is important in understanding rheumatoid arthritis as well as other rheumatic and immunologic diseases. Rheumatoid factors are IgG, IgA or IgM antibodies to IgG. They occur in 70-95% of patients with rheumatoid arthritis but may also be found in sera from some patients with other rheumatic, infectious or chronic diseases. Those patients with rheumatoid factors in their serum are prone to develop progressive and severe arthritis. Although the role of rheumatoid factors in the pathogenesis of rheumatoid arthritis is not yet entirely clear, it is believed that they participate in the processes of complement activation and/or immune-complex phagocytosis which are important in the production of inflammatory synovitis.

Rheumatoid arthritis (RA) can be a confusing and discouraging illness to manage; yet study of certain aspects has provided significant and exciting insights into host immune mechanisms. The most striking immunologic abnormality among patients is the presence of an "autoantibody," rheumatoid factor (RF). An appreciation of its role focuses upon many clinical and immunological considerations in rheumatoid arthritis. This review will briefly highlight the nature, methods of detection, diagnostic applications, biological properties and pathogenetic role of the rheumatoid factor in disease.

Nature of Rheumatoid Factors

The ability of sera from RA patients to agglutinate sensitized sheep red blood cells was first recognized in 1922. By the late 1950s this phenomenon was widely appreciated and was adapted for use in serological diagnosis of the condition.[1,2] During the 1960s a number of investigators convincingly established that rheumatoid factor was antibody to IgG.[3,4] Early studies identified it as 19S IgM antibodies. Subsequent work has revealed that RFs are not restricted to this class of immunoglobulins but also occur as IgG, IgA and 7s IgM antibodies.[5,6] Thus "rheumatoid factor" is more properly termed "antigammaglobulins"—reflecting the multiplicity of antibodies of at least three immunoglobulin classes directed toward (IgG) gammaglobulin.

Detection of Rheumatoid Factors

Many test systems for the detection of antigammaglobulins have been developed.[1,2,7] Those in general clinical use utilize the agglutinating capacity of the high molecular weight 19S IgM RFs. The most commonly used tests have probably been the sensitized sheep cell agglutination test[2] and latex fixation[1] tests. Sheep erythrocytes can be sensitized with subagglutinating amounts of antibody and then reacted with test serum. Agglutination occurs in the presence of antigammaglobulins. The serum must be preheated to inactivate complement and must be absorbed with unsensitized sheep cells to remove heterophile antibodies, rendering performance of this test somewhat cumbersome. Latex fixation tests employ latex particles coated with aggregated gammaglobulin. These agglutinate in the presence of antigammaglobulins. The test is rapidly performed and is now available in kit forms suitable for office and hospital use.

Several precautions must be noted in carrying out and interpreting these tests. Some sera may contain thermolabile nonspecific agglutinators (probably C1q, a portion of the first component

Dr. Panush is Assistant Professor of Medicine, Division of Infectious Diseases and Immunology, Department of Medicine, University of Florida College of Medicine and the Medical Service, Veterans Administration Hospital, Gainesville.

of the complement system[8] or inhibitors of the reaction.[9] Thus "false-positive" results can be obtained, usually in patients without rheumatoid arthritis, if sera are not heat-inactivated (56°C for 30 minutes) prior to testing. "False-negative" results, due to inhibitors of the reaction present in sera in low titers, can occasionally be found if serial dilutions of the test sera are omitted.

There continues to be considerable interest in improving available clinical diagnostic methods. A number of additional methods of testing for RF have recently been devised but these are currently used as research procedures. A sensitive radioimmunoassay for IgM RFs has been developed.[10] IgG immunoadsorbents have been used for adsorption, elution and subsequent quantitative and qualitative determination of purified RFs of the different immunoglobulin classes.[5,11] An immunofluorescent method has been reported[12] and rosette formation by rheumatoid lymphocytes has also been used.[13]

The sensitivity and specificity of test methods differ. An ideal test for rheumatoid arthritis of course would be both highly sensitive and specific, i.e., identify all patients with that diagnosis but no other patients. It will be seen, however, that antigammaglobulins occur not only in these patients but also in patients with other diseases. Some of the investigational methods can identify RFs in all patients with rheumatoid arthritis but will also measure those present in other individuals. A yet there is no method that will detect only those antibodies present in RA patients only. Thus RF testing remains one of many diagnostic criteria for evaluating rheumatoid arthritis. Of the tests available for routine clinical use it is felt that the sheep cell test is more specific but less sensitive than latex agglutination tests. The latex tests, and particularly slide tests, appear more sensitive and less specific. These latter tests have the added advantage of being easily performed.[4,6,7]

Incidence of Rheumatoid Factors In Various Disease States

Although RFs are common in patients with rheumatoid arthritis they are by no means specific for this disease. RFs are found in a number of other disease states and clinical circumstances. The incidence of positive tests in diseases is difficult to accurately assess because of the variability of different test methods and study populations.[2-4,7] It can be estimated that RF can be detected by serologic tests in the following percentages of patients: RA 70-95%, Sjogrens' syndrome 80-95%, poly-dermatomyositis 50%, subacute bacterial endocarditis 50%, progressive systemic sclerosis 25-30%, systemic lupus erythematosus 20-30%, hepatic disease 20-30%; juvenile rheumatoid arthritis 20%, chronic infectious diseases 15-25%, sarcoidosis 15-20%, patients over 60 years of age 10-20%, rheumatoid spondylitis $<5\%$, rheumatic fever $<5\%$, normal individuals $<5\%$ and osteoarthritis 5-20% (incidence comparable to age-matched "normal" individuals).

Clinical Significance of Rheumatoid Factors In Rheumatoid Arthritis

Determining the presence or absence of RF in patients with rheumatoid arthritis provides useful clinical as well as diagnostic information. The presence of RF has often been associated with poor prognosis, progressive and unremitting disease course, significant functional impairment, presence of subcutaneous nodules, high erythrocyte sedimentation rate, a large number of joints involved, radiological evidence of joint destruction and frequent extra-articular complications such as vasculitis, pleuropulmonary disease, pericarditis or episcleritis.[4,5,14] Tests for RF that are positive usually remain so during the course of disease. Titers do not tend to fluctuate with disease activity. Titers may fall with sustained remission, plasmaphoresis or treatment with corticosteroids, penicillamine, gold, antimalarial or immunosuppressive drugs. Conversely many patients in long-term remission retain high RF titers in their serum.

Biological Properties of Rheumatoid Factors

Once it was recognized that RFs were prevalent in high titers among most patients with rheumatoid arthritis, attempts to define their biological role were undertaken in hopes of clarifying mechanisms of disease production.

In vitro studies have shown that RFs possessed a number of diverse properties which could be either harmful or protective. Many, but not all, of these biological activities can fit into a pathogenetic scheme for rheumatoid arthritis. Some of these properties will be summarized and then the role of RF will be considered. IgM RF has been shown to neutralize infectivity of virus-antibody complexes.[15] Both IgG and IgM RFs, under appropriate conditions, are capable of interacting with aggregated gammaglobulin and activating the classical complement system.[16] Levels of serum and synovial fluid IgG and IgM antigammaglobulins are inversely proportional to serum and

synovial fluid complement levels.[5] IgG-anti-IgG complexes have been identified in rheumatoid joints and similarly are inversely proportional to joint fluid complement measurements.[17] RF may block IgG opsonins and impair phagocytosis, may actually inhibit complement activation under certain conditions and impair complement dependent phagocytosis as well.[4,18] RF may attach to circulating immune complexes and facilitate immune elimination—or tissue deposition—of complexes.[4] RF may be capable of activating the kinin system which may be important in the inflammatory response.[4] RFs are weak stimulants for lymphocytes.[4] Injected into rat mesentery, 19S-IgM RF induced changes of vasculitis.[19]

Role of Rheumatoid Factors in Pathogenesis of Rheumatoid Arthritis

Present conceptualization of the immunopathology of rheumatoid synovitis considers that intra-articular activation of the complement system occurs. This results in the liberation of biologically active products from complement proteins capable of initiating an inflammatory response. Phagocytosis of complement and immunoglobulins (presumably as immune complexes) by polymorphonuclear cells takes place with resultant liberation of lysosomal enzymes. These enzymes are also capable of causing tissue injury with inflammation in the joint cavity.[20]

Most observers agree that RFs participate in some manner in these immunological events. The principal supporting evidence is clinical observations associating the presence of large quantities of RFs with severe joint disease[5,14] and the demonstration of an inverse relationship of antigammaglobulins and complement levels.[5,17,20]

The precise role of RFs in rheumatoid inflammation is not yet clear. It is thought that IgG and IgM RFs, combined with IgG, may themselves activate the complement pathway. Alternately RFs may enhance the interaction of other immune complexes with phagocytic cells. It is anticipated that future developments will further clarify concepts of the pathogenesis of this puzzling disease.

Summary

Certain aspects of rheumatoid factors (RFs), particularly their role in disease, are reviewed. RFs are more properly termed antigammaglobulins since they are IgG, IgA and IgM antibodies to IgG. Of the many methods of testing for their presence, the latex fixation test seems most suitable. It is easily performed and sensitive although somewhat nonspecific. RFs occur in 70-95% of patients with rheumatoid arthritis but also occur in approximately 20-50% of patients with other rheumatic diseases or certain chronic or infectious diseases. Rheumatoid arthritis patients who have RFs in their serum are more likely to have progressive or severe disease than rheumatoid factor-negative patients. Although the role of RFs in the pathogenesis of rheumatoid arthritis is not yet clear, it is thought that RFs participate in complement activation and/or immune complex phagocytosis; both of these processes liberate biologically active products capable of sustaining inflammatory synovitis.

References are available from the author upon request.

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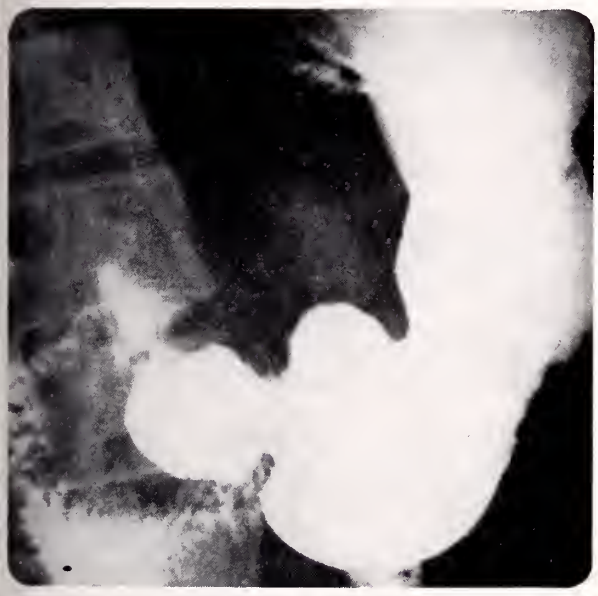
Value of a smile. It costs nothing but creates much, it enriches those who receive without impoverishing those who give, it happens in a flash and the memory may last forever.

—Dale Carnegie

The Upper Functional G.I. Disorder

The Pseudo-ulcer

Ulcer-like symptoms: no G.I. pathology



X-ray demonstrates normal stomach.

The patient is convinced he has an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

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*Rome HP, Brannick TL: Orientation and mechanism of functional disorders; clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W. B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

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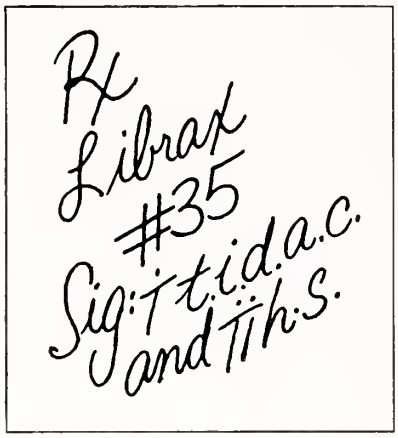

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Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

SEPTEMBER

Current Status of Pain Control, Sept. 6-7, Hilton Hotel, Gainesville.**

Perinatology for the Community Physician, Sept. 11-14, Disney World, Lake Buena Vista, Florida**

Teaching Conference in Radiology, Sept. 11-15, Doral Country Club, Miami*

Postgraduate Seminar in Pediatric and Adult Urology, Sept. 23-26, Playboy Plaza Hotel, Miami*

Pediatric Cystic Disease of the Kidney, Sept. 14, J. Hillis Miller Health Center, Gainesville**

Renal Medicine for the Practitioner, Sept. 19-21, Tarpon Springs, Florida**

Fracture Bracing Workshop, Sept. 21-22, University of Miami School of Medicine*

Postgraduate Seminar in Pediatric-Adult Urology, Sept. 23-26, Playboy Plaza Hotel, Miami*

Antibiotics in the Management of Infectious Diseases, Sept. 28, Gainesville**

Third Annual Postgraduate Course in Gastroenterology (Dates not decided), University of Miami School of Medicine*

By Arrangement: In-Service Tutorials in Family Medicine; Neonatology; Oncology, Ophthalmology; Otolaryngology; Pediatric Cardiology; Radiology; Renal Disease, Hypertension and Renal Dialysis; Urology*

By Arrangement: On-Site Community-Hospital Program: "A Positive Approach to Cancer Diagnosis and Treatment." University of Miami School of Medicine, the Comprehensive Cancer Center of Greater Miami, National Cancer Institute, U.S. Public Health Service, and co-sponsored by the American Cancer Society, Florida Division*

By Arrangement: Visiting Lecturers Program—a program designed to provide continuing education based on specific requests from local medical groups and hospitals*

OCTOBER

Common Allergic Diseases of Children, Oct. 5, Gainesville**

Emergency Medicine, Oct. 6-8, Sheraton Towers Hotel, Orlando**

Fundamental and Clinical Aspects of Internal Medicine, Oct. 6-19, Sheraton Four Ambassadors Hotel, Miami*

Twenty Third Annual Seminar, Florida Diabetes Association, Oct. 11-12, Disney World, Lake Buena Vista, Florida. For information: J. T. Blackburn, M.D., 1351 S. Hickory St., Melbourne 32901

Post-Doctoral Refresher Training Program for Foreign Medical Graduates, Oct. 14, 28 & July 17, 1975, Rosenstiel Medical Sciences Building, Miami*

Orthopaedics and Arthritis, Oct. 18-20, Americana Hotel, Miami Beach*

▶ American College of Gastroenterology, Oct. 20-23, Americana Hotel, Miami Beach. For information: Mr. Daniel Weiss, 299 Broadway, New York 10007

▶ American College of Surgeons, Clinical Congress, Oct. 21-25, Miami Beach. For information: C. Rollins Hanlon, M.D., 55 E. Erie St., Chicago 60611

Diagnosis and Surgical Management of Gastrointestinal Diseases in Children, Oct. 26, J. Hillis Miller Health Center, Gainesville**

Reconstruction in and About the Orbit, Oct. 25-26, Innshooke, Florida (Tampa area), University of Florida College of Medicine**

Intensive Colposcopy, Oct. 25-27, Sonesta Beach Hotel, Key Biscayne*

▶ American Society of Therapeutic Radiologists, Oct. 30-Nov. 4, Sonesta Beach Hotel, Key Biscayne. For information: Sheila A. McGing, 20 N. Wacker Dr., Rm. 2920, Chicago 60606

NOVEMBER

Tumors in Children, Nov. 2, J. Hillis Miller Health Center, Gainesville**

▶ Interstate Postgraduate Medical Association of North America, Nov. 4-7, Diplomat Hotel, Hollywood. For information: Mr. Roy T. Ragatz, Box 1109, Madison, Wisc. 53701

Cardiorespiratory Problems in the Pediatric Patient, Nov. 9, University Hospital of Jacksonville Auditorium, Jacksonville**

Hand Surgery—1974, Nov. 15-17, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Miami*

▶ American Association for Clinical Immunology and Allergy, Nov. 21-24, Pier 66, Ft. Lauderdale. For information: John L. Dewey, M.D., P.O. Box 912, DTS, Omaha, Nebraska 68101

Progress and Prospects in Health Care Distribution Systems, Nov. 25-27, Fontainebleau Hotel, Miami Beach*

Pediatric Hematology, Nov. 30, J. Hillis Miller Health Center, Gainesville**

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▶ National meetings being held in Florida.

DECEMBER

"Changing Concepts in Infectious Diseases for Obstetrics & Gynecology," Dec. 5-6, Hilton Hotel, Gainesville**

▶ Southern Surgical Association, Dec. 9-12, Boca Raton. For information: W. Dean Warren, M.D., 1364 Clifton Rd., N.E., Atlanta, Ga. 30322

13th Biennial Cardiovascular Seminar—"Tools and Techniques of the Practicing Cardiologist," Dec. 12-14, Sheraton Four Ambassadors Hotel, Miami. For information: Thomas J. Noto Jr., M.D., 5080 Biscayne Blvd., Miami 33137

JANUARY

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 22-25, Hyatt House, Miami Beach*

Other Approved CME Meetings

Neonatal Care — 1974 (Wednesday) 7:30 p.m.-10:00 p.m., Tampa General Hospital, Tampa

Pediatric Grand Rounds (Friday, holidays excluded) 9:15 a.m.-10:00 a.m., University Hospital, Jacksonville

Pediatric Conference (Wednesday) 9:15 a.m.-10:00 a.m., Jacksonville Children's Hospital, Jacksonville

Graduate Level Courses in Family Practice (Weekdays), University of Miami School of Medicine*

Weekly Teaching Conferences (Tuesday), Morton E. Plant Hospital, Clearwater

Peer Teaching Conferences (Wednesday), St. Vincent's Hospital, Jacksonville

In-Service Tutorial in Pediatric Cardiology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Neonatology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Radiology (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer Diagnosis & Treatment (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer In-Hospital Training Program (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Otolaryngology (Arranged), University of Miami School of Medicine*

Family Practice Grand Rounds (1st 3 Thursdays), St. Joseph's Hospital, Tampa

Consultant Teaching Seminars (Weekly), Alachua General Hospital, Gainesville

In-Service Training in Family Medicine (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Cardiology (Arranged), University of Miami School of Medicine*

Courses of Instruction in Coronary Care for Practicing Physicians (Arranged), University of Miami School of Medicine*

Practical Aspects of Family Medicine (Arranged), University of Miami School of Medicine*

Cardiac Conference (Tuesday) 4:30 p.m.-5:30 p.m., North Florida Regional Hospital In-Service Classroom, Gainesville

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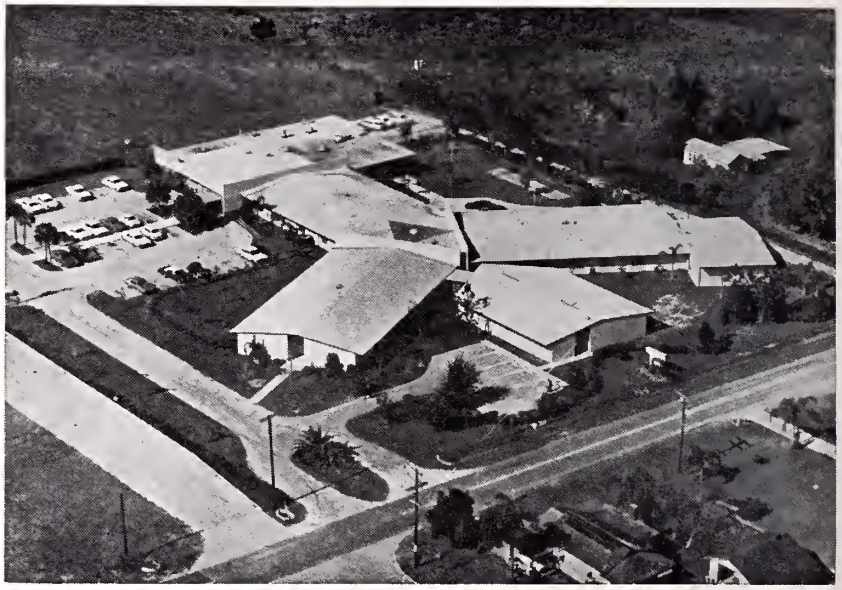

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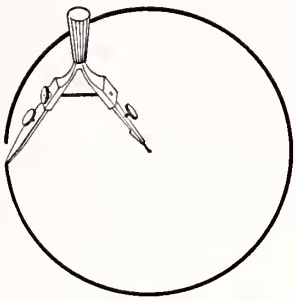

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Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis.* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal, unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

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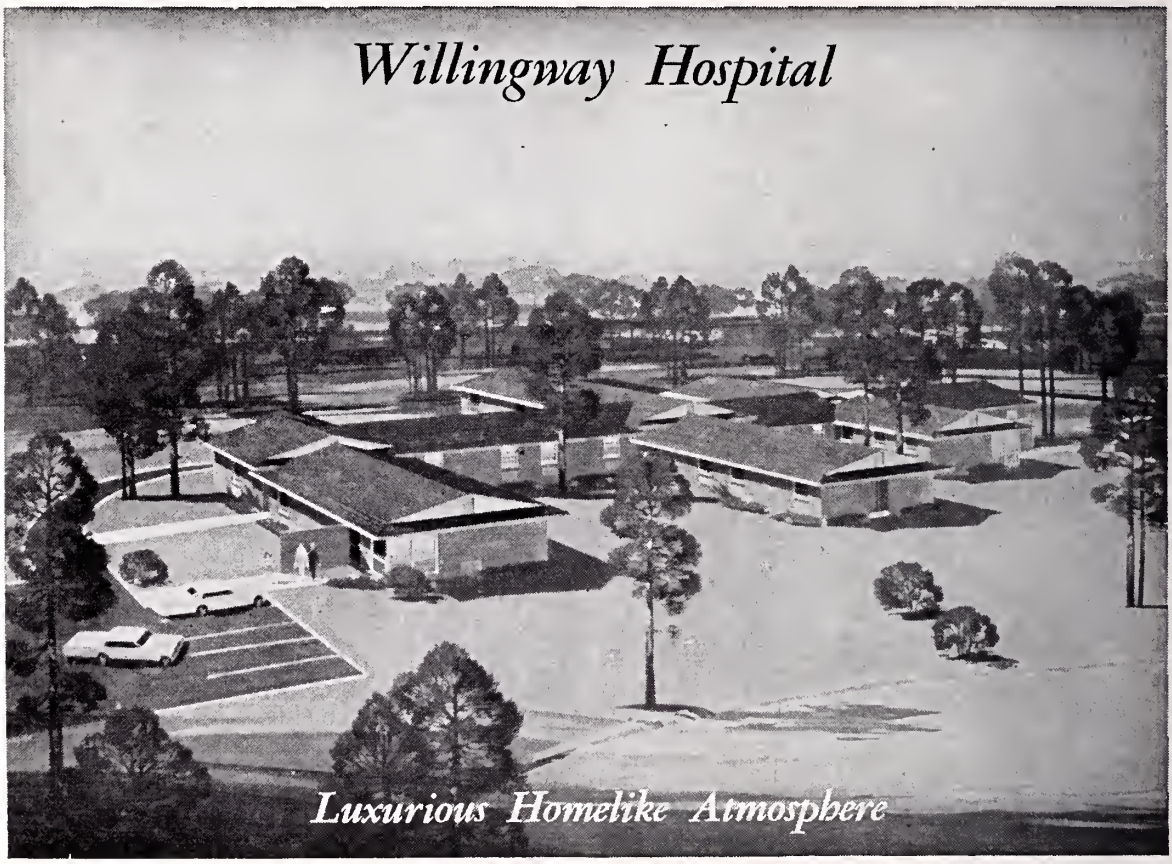

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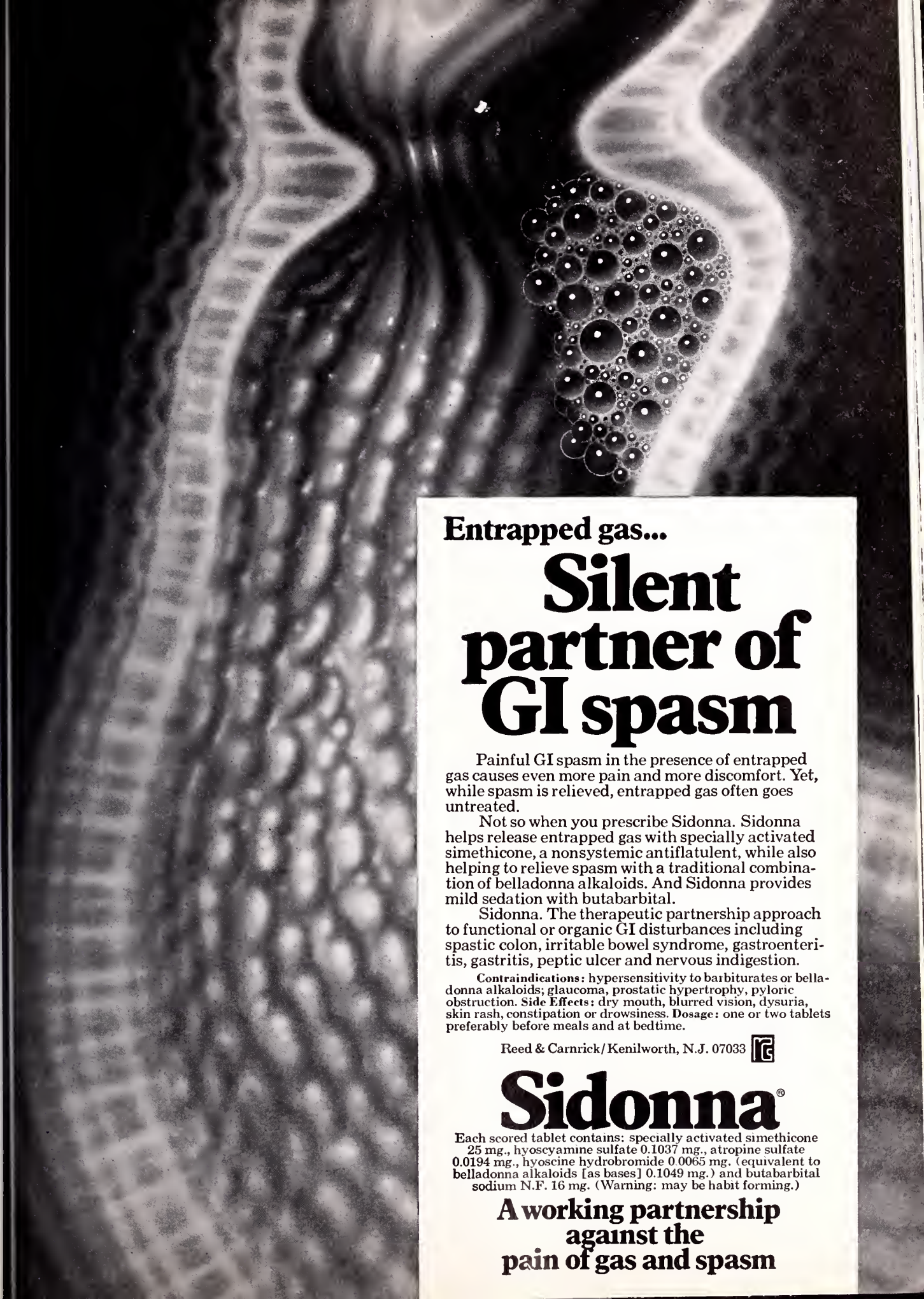

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Florida Organization of Medical Interest Meetings and Officers

Organization	President	Secretary	Annual Meeti
Florida Medical Association	Thad M. Moseley, Jacksonville	James W. Walker, Jacksonville	Bal Harbour, April 23-27,
Florida Specialty Societies			
Allergy Society	Angelo P. Spoto, Lakeland	Gerard F. Carter, Miami	
Anesthesiologists, Society of	George T. Edwards, Ft. Lauderdale	John C. Kruse, Jacksonville	
Chest Phys., Fla. Chap. Am. Coll.	Eugene J. Sayfie, Miami	Roberto Llamas, Miami Beach	
Dermatology, Society of	Charles C. Dugan, W. Palm Bch.	Hillard J. Halpryn, Hialeah	
Emergency Phys., Fla. Chap.	Bruce S. Webster, Orlando	John F. Davison, Miami	
Family Physicians	Joseph P. Hendrix, Pt. St. Joe	Charles A. Dunn III, Miami	
Gastroenterologic Society	James L. Borland Jr., Jacksonville	John J. Kennedy, Orlando	
Internal Medicine	Lawrence E. Geeslin, Jacksonville	Melvin C. Dace, Gainesville	
Nephrology Society	Michael J. Pickering, Lakeland	William W. Anderson, Miami	
Neurology Society	Jacob Green, Jacksonville	Richard L. Parker, Winter Park	
Neurosurgical Society	Mason Trupp, Tampa	Hubert A. Aronson, Miami	
Obst. & Gynec. Society	William T. Patton, Pensacola	George N. Lewis, Tallahassee	
Ophthalmology Society	Curtis D. Benton, Ft. Lauderdale	Raymond J. Sever, Temple Terrace	
Orthopedic Society	Robert E. Ingersoll, Key Largo	James F. Richards, Orlando	
Otolaryngology Society	George T. Singleton, Gainesville	James C. Garlington, Gainesville	
Pathologists Society	Laudie E. McHenry, Melbourne	Pablo Enriquez, Gainesville	
Pediatric Society, Fla. Chap. Am. Acad. of Pediatrics	David R. Gair, Miami	Stephen P. Gyland, Jacksonville	
Pediatric Surgeons Assn.	H. Warner Webb, Jacksonville	James L. Talbert, Gainesville	
Phys. Med. & Rehab. Soc.	Justine L. Vaughen, Gainesville	Charles J. Kurth, Orlando	
Physicians, Am. Coll. of	Chester Cassel, Miami		
Plastic & Recon. Surgery Soc.	Harold G. Norman, Coral Gables	Ian L. Matheson, Tampa	
Preventive Medicine Society	R. Chris Brown, Largo	Joseph A. Baird, Belleair Beach	
Proctologic Society	Thomas F. Nelson, Tampa	M. L. Carbonell, Miami	
Psychiatric Society	Stanley I. Holzberg, Coral Gables	Daniel S. Hellman, St. Petersburg	
Radiological Society	Ralph C. Aye, Tampa	Paul J. Popovich, Melbourne	
Rheumatology Society	Wilbur J. Blechman, N. Miami Bch.	Louis R. Ricca, St. Petersburg	
Surgeons, Fla. Chap. Am. Coll.	Nelson H. Kraeft, Tallahassee	George L. Irvin III, Miami	
Surgeons, General, Fla. Assn.	George H. Welch Jr., St. Pete	Robert H. Hux, Leesburg	
Surgeons, Fla. Div., Int. Coll.	Julian A. Rickles, Miami Beach		
Surgeons, Thoracic Society	Thomas O. Gentsch, Miami	Robert B. Trumbo, Orlando	
Urological Society	John I. Williams, Ft. Lauderdale	R. Benjamin Moore, W. Palm Bch.	
FLORIDA DIVISION:			
American Cancer Society	Charles W. Lantz, Hollywood	Charles Prescott, Tallahassee	Ft. Lauderdale, Nov. 8-10,
Arthritis Foundation	Samuel P. Lewis, Hollywood	T. K. Grahn, Holmes Beach	Tampa, May 24, 1975
Blue Shield of Florida, Inc.	J. W. Herbert, Jacksonville	John S. Slye, Jacksonville	Bal Harbour, April 23-27,
Board of Medical Examiners	Carl C. Mendoza, Jacksonville	Victor J. Martinez, Tampa	Tampa, Jan. 5-7, 1975
Crippled Children & Adults	J. Ward Dougherty, Lutz	Stephen Bullock, Lynn Haven	Jacksonville, Oct. 25-27, 19
Epilepsy Foundation	Dolores S. Benedict, W. Palm Bch.	Joyce W. Acton, Jacksonville	Jacksonville, Aug. 31, 1974
Florida Diabetes Association			Disney World, Oct. 11-12,
Florida Heart Association	Matthew H. Bradley, Miami Bch.	S. Lee Crouch, Hallandale	Miami Beach, May 25, 19
Florida Kidney Foundation	J. R. Bond, Jacksonville	Patricia Miller, Pensacola	November 1974 (to be ann
Florida Lung Association	Solon J. Ellmaker, Orange Park	Wm. E. Culbreath, St. Pete	Tampa, April 24-25, 1975
Florida Physicians Assn., Inc.	James T. Cook Jr., Marianna	Paul C. Harding, Orlando	Bal Harbour, April 23-27,
Leukemia Society of America	Irving J. Whitman, Miami	Robert H. Newman, Miami	(Place undecided) June 19
Mental Health Association	John Madden, Tallahassee	Mrs. Wilbur Donner, Ft. Pierce	Naples, Oct. 17-19, 1974
Occupational Medical Assn.	Joseph A. Baird, Belleair Beach	Eugene L. Horger, Deerfield Beach	Jacksonville, October 10-12
Prevention of Blindness	Robert W. Andrew, Tampa	Rosemarie Willaford, Tampa	Tampa, January 24-25, 19
Retarded Children	Thomas A. Clark, Tampa	Dolores Cole, Satellite Beach	Jacksonville, Sept. 12-14,
United Cerebral Palsy	Grace B. Futch, Pensacola	Malcolm Anderson, W. Palm Bch.	Panama City, Nov. 15-16,
Woman's Auxiliary to FMA	Mrs. Ray E. Murphy, Pompano Beach	Mrs. Maurice Hodge, Rockledge	Bal Harbour, April 23-27,

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

Classified Ads

physicians wanted

Family Practitioners

WANTED—Family practitioner to join established physician in busy two-doctor practice. Salary and/or percentage first year with PA benefits. Lower Florida East Coast. Phone (305) 732-2701.

FAMILY PRACTITIONER to join twenty-three multispecialty group in St. Petersburg within next twenty-four months. Excellent financial arrangements, corporate benefits, and recreational facilities. Please send curriculum vitae. Write C-596, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL PRACTITIONER needed by expanding multispecialty group in northwest Florida. Excellent opportunity for U.S. trained physician. Guaranteed salary, then partnership. New hospital just opened, new clinic building being designed. Contact J. C. Wilson, M.D., P.O. Drawer MM, Ft. Walton Beach, Florida 32548.

GENERAL PRACTICE: Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

GENERAL PRACTITIONERS AND INTERNISTS NEEDED. Very desirable southeast coast community. Excellent hospital facilities. Florida license required. Inquiries regarding practice in our county can be sent to Box 324, Stuart, Florida 33494. Phone: (305) 287-5200, extension 200 or 246.

FAMILY PRACTITIONER (AAFP qualified) wanted for north Florida college town. Busy practice in spacious, new two-man office building one half block from hospital. Enjoy getting out of the big city. Contact W. J. Bibb, M.D. (age 43), P.O. Box 179, Madison, Florida 32340. Phone Collect: (904) 973-6561.

Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

MIAMI, FLORIDA AREA. Seven man multispecialty, fee-for-service group is seeking an internist to join the group. Generous first year profit guarantee. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

ORTHOPEDIC SURGEON WANTED: Experienced, aggressive, to join quality specialty group. Write W. A. Clark, M.D., P.O. Box 1376, New Port Richey, Florida 33552 or Phone: (813) 842-9561.

E.N.T. WANTED: To join quality specialty group with no opposition. Write W. A. Clark, M.D., P. O. Box 1376, New Port Richey, Florida 33552 or Phone: (813) 842-9561.

RADIOLOGIST WANTED: Certified and experienced to join quality specialty group. Write W. A. Clark, M.D., P. O. Box 1376, New Port Richey, Florida 33552 or Phone: (813) 842-9561.

PSYCHIATRIST for hospital and office practice in Florida's most prosperous city. Seven psychiatrists will welcome you. New 75-bed hospital underway. Office space available. Contact Robert G. Head, M.D., 1630-A North Plaza Dr., Tallahassee, Florida 32303.

INTERNIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-619, P. O. Box 2411, Jacksonville, Florida 32203.

OTOLARYNGOLOGIST needed by expanding fourteen man clinic located in seacoast city, Florida panhandle. Guaranteed salary with potential to $40,000 to $60,000 during two year associateship and then full partnership. New hospital. New clinic building on drawing board. Send photograph and credentials to C-620. P. O. Box 2411, Jacksonville, Florida 32203.

OPHTHALMOLOGIST WANTED: Attractive opportunity in north central Florida. Community has well equipped, new 128-bed hospital and does not currently have an ophthalmologist. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

WANTED: FAMILY PRACTITIONER, PEDIATRICIAN OR OB/GYN, one or two. To occupy new 1200 sq. ft. office suite with four exam. rooms. Within two blocks of two hospitals. Ten miles from Disney, rapid growth area. Incentive offered. Contact Mrs. Pitts, 110 W. Drury, Kissimmee, Florida 32741 or phone (305) 846-4877.

INTERNIST WANTED—board eligible or certified with subsequently training in cardiology to join physician in growing private practice, Fort Lauderdale area. Salary leading to partnership. Some experience preferred. Write C-652, P.O. Box 2411, Jacksonville, Florida 32203.

WANTED: SEMI-RETIRED SURGEON to assist in O.R., make rounds, apply casts, cover E.R. on alternating weekends. Call (305) 373-8333.

Miscellaneous

Family Practitioner, Otolaryngologist, Pediatrician, Internist-Rheumatologist, and Internist-Pulmonary Disease needed for outstanding practice opportunities. Forty-six physician medical group, affiliated with 312 bed hospital, located on Florida's Gulf Coast. Population doubling in five years. Advantages of group practice combined with prerogatives of solo practice. Fee for service arrangement with substantial drawing account first year. No investment required. For full details, contact D. M. Schroder, Mease Hospital and Clinic, Dunedin, Florida 33528, telephone (813) 734-6365.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccousukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

DEVELOPING MULTISPECIALTY GROUP oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Radiologists, Internists, Cardiologists, Pediatricians, General Surgeons and General Practitioners. Contact: H. D. Williams, M.D., President, Williams, Abbey & Sells, M.D's, P.A., Richey Medical Center, P. O. Box 1000, New Port Richey, Florida 33552. (813) 842-8494.

EMERGENCY ROOM PHYSICIAN—FLORIDA CAPITAL CITY: to join other physicians in full E.R. coverage of 511-bed general hospital. 42 hour week, Florida license required. Beautiful location in university town, abundant fishing, water sports and hunting. Excellent schools, choice home sites. Minimum income of $40,000 with opportunity to increase. Contact Dr. George H. Evans, Chairman, Emergency Room Committee, Tallahassee Memorial Hospital, Tallahassee 32303.

INTERNIST OR GENERALIST WANTED to join two doctor practice in internal medicine and geriatrics. Beach area Fort Lauderdale. Florida license. Salary first six months, then partnership. Excellent hospital privileges. A. Joseph Pitone, M.D. and Louis L. Amato, M.D., 2600 N.E. 9th St., Fort Lauderdale, Florida 33304. Phone: (305) 564-7597.

EMERGENCY ROOM PHYSICIAN NEEDED to increase staff of new facility serving 900-bed general hospital in town of 40,000, in stable, attractive community in central Florida lake district. U. S. training and citizenship essential. Previous practice or advanced training will be given prime consideration. Wire or write John F. Flanagan, M.D., 1600 Lakeland Hills Boulevard, Lakeland, Florida 33801.

PHYSICIAN DIRECTOR WANTED: General medical outpatient clinic. Progressive college community in central Florida. Excellent opportunity for the right person. Training in Family Practice or Internal Medicine preferred, Florida license required. Salary commensurate with training and experience. Contact: Raymond W. Wright, Administrator, Alachua General Hospital, Gainesville, Florida 32602; or call collect (904) 372-4321.

situations wanted

GENERAL INTERNIST: 34 years old, board eligible, wants association to physician or group. Speaks English and Spanish well. Write C-651, P. O. Box 2411, Jacksonville, Florida 32203.

practices available

PRACTICE AVAILABLE: Internal medicine and cardiology practice, established 40 years. Walking distance to hospital. Will work and introduce to patients. Write G. C. Ferrante, M.D., 501 S. MacDill Avenue, Tampa, Florida 33609.

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ORLANDO—MEDICAL SUITE in modern building, prime location, near hospitals and schools, loads of parking, doctors needed in this area. Phone: (305) 293-6020.

MEDICAL OFFICE FOR RENT 1,800 sq. ft. in Brevard county high income area, near hospital. Excellent opportunity for instant practice. Phone: (305) 631-0606.

HOLLYWOOD, FLORIDA: New medical building in Emerald Hills Medical Square. Excellent location near hospital. Ample parking. Contact: J. Schneider, M.D., 1131 North 35th Ave., Hollywood, Florida 33021. Phone: (305) 961-6774

VACATION ON SANIBEL: Luxurious air-conditioned condominium on Gulf beach. Two bedrooms, two baths, porch, pool, etc. Minimum rental one week. Contact J. Willson, 119 Dixboro Rd., Ann Arbor, Michigan 48105.

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NOW LEASING: 60,000 sq. ft. medical building now under construction in north Tampa, next door to University Community hospital, a private 400-bed general hospital, same area as medical school and VA hospital. Ready for occupancy early in 1975. Call Tampa 971-5353 or 977-0144.

FLORIDA, GOLD COAST. New ultramodern condominium office building. Construction starting August 1974 ready for occupancy about April 1975. Design your office while building is being constructed. Contact Lavernia, P.A., 1607 S. E. 3rd Court, Deerfield Beach, Florida 33441. Phone: (305) 390-1771.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P. O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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to help reduce clinically significant anxiety and thereby help improve patient receptivity

Librium® up to 100 mg daily in severe anxiety (chlordiazepoxide HCl)

Please see following page.

Symptom of excessive anxiety:

The patient may have difficulty in accepting medical counsel.

Clinical experience has shown that some unduly anxious patients may tend to deny or minimize their illness and therefore resist seeking or following medical advice. Through its antianxiety action, adjunctive Librium (chlordiazepoxide HCl) can often calm the emotionally tense patient, thereby encouraging physician-patient rapport and, on occasion, making it easier for the patient to accept medical counsel.

for relief of excessive anxiety

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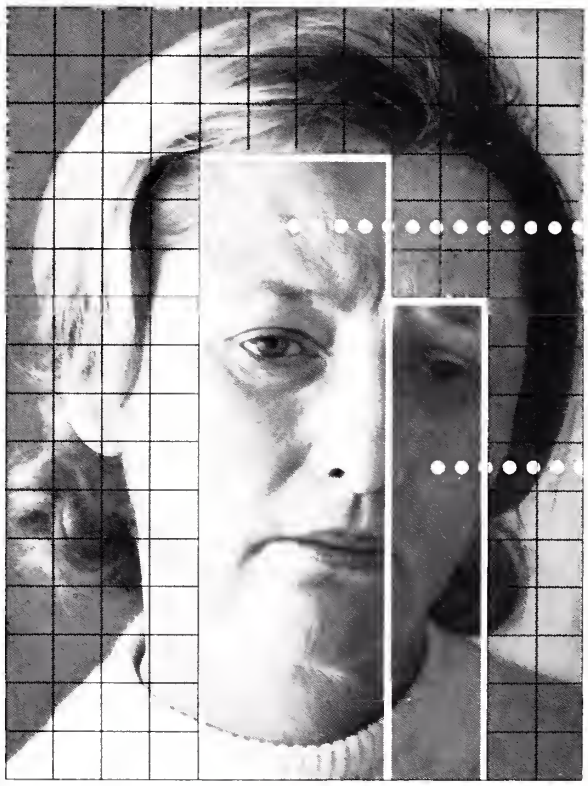


Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

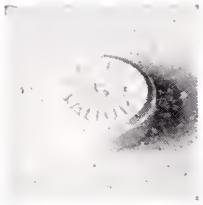
According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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OCTOBER COVER: FMA Executive Vice President W. Harold Parham makes an appropriate response upon being awarded the honorary Doctor of Health Administration degree by the University of Florida during a session of the House of Delegates in May. Participating in the special convocation were (left to right): Bernard J. Fogel, M.D., Assistant Vice President for Medical Affairs, University of Miami; Edmund F. Ackell, M.D., Vice President for Health Affairs, University of Florida; Donn L. Smith, M.D., Dean of the University of South Florida College of Medicine; Jere W. Annis, M.D., Chairman of the University of Florida Medical Advisory Committee; and Chandler A. Stetson, M.D., Dean of the University of Florida College of Medicine. Dr. Parham completes 25 years of dedicated service to FMA this month. See page 774.

President's Page

More Government in Medical Care

Through the past month I have reviewed 20 legislative proposals before the Congress of the United States relating to national health insurance. They differ in detail but all involve government more fully and directly in health and medical care.

Each proposal reflects in part the philosophy of its sponsor. The Kennedy-Griffith bill offers 100% payment for all covered services, compulsory participation, and financing by a "health security" tax yet to be created. The Long-Ribicoff catastrophic insurance plan provides basic benefits for patients designated as categorically poor but others would be required to assume financial responsibility for basic medical expenses. It would be financed by increasing Social Security taxes. The AMA plan, Medicredit, offers total coverage for all persons under age 65 through private insurance carriers with the government paying part of the premium, depending upon the family income. Medicare would not be affected. From these proposals and others will come ideas which the proper committee will incorporate into a bill for presentation to the 94th Congress in 1975.

President Ford has stated he wants a health care bill. The tone of the Congress is favorable for passage of some kind of legislation. The problem seems to be how much coverage is essential for proper care of the people, to what degree government can finance a plan, obtaining medical personnel to provide all things for all people, and what will be the role of the private health insurance industry.

We physicians recognize that the employer controls his employees in a number of ways. Under a government controlled plan to provide health and medical care, we believe we could find ourselves licensed, assigned to an area of practice, and told how to treat as well as the charge for treatment by a government agency. Luckily, some legislators also recognize the danger.

Unfortunately, forces within the Congress also influence legislative action. The Social Security advocates are at odds on occasion with health, education and welfare methods. Two bills are in the Congress which would place health matters in the Interstate and Foreign Commerce Committee of the House of Representatives, leaving the Ways and Means Committee only the Social Security input into health legislation. Such a change would influence the tone of a final bill on health. Some congressmen have expressed a desire to wait for this decision before committing themselves on health matters. Labor, advocating full health coverage and Social Security financing, believes that there will be a more liberal and sympathetic Congress following the next election and wishes to delay a decision on any plan until next year.

As a citizen paying taxes and practicing medicine, I hope that logical thinking prevails in whatever the action by Congress, that the private health insurance industry will participate fully in financing medical care and that the physician will continue to have the freedom to treat his patients in the environment of his choice, as he believes best.

Thad Moseley

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RIEF SUMMARY
or full prescribing information, see package *rcular.)*
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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are ontraindicated in patients with (1) markedly mpaired liver function; (2) known or suspected arcinoma of the breast, except those cases of rogressing disease not amenable to surgery or rradiation occurring in women who are at least years postmenopausal; (3) known or suspected strogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic lisorders, thrombophlebitis, cerebral embolism, r in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given o women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of he physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation f undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. **7352**

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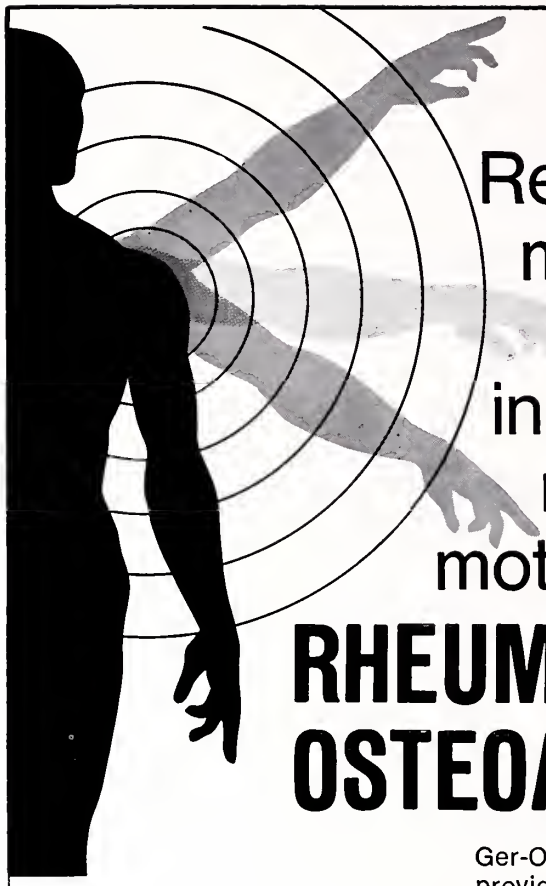

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AVAILABLE: 1½ and 4 oz. cans. Approximately 125 applications in each 4 oz. can.

1. Gordon, E. E. and Haas, A., Indust. Med. & Surg. 28:217, May, 1959.

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AEROSOL FOAM FOR MASSAGE

methylsalicylate 30% and benzocaine 3% in a specially processed emulsion

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DESCRIPTION: WANS® Children Supprettes™ contain pyrilamine maleate 25 mg and sodium pentobarbital ½ gr (30 mg) (*Warning:* may be habit forming) in rectal suppository form. *CONTRAINDICATIONS:* Infants under 6 months. Acute intermittent porphyria, known hypersensitivity to barbiturates or antihistamines, known previous barbiturate addiction, severe hepatic impairment, CNS injury and presence of uncontrolled pain. *WARNINGS:* Barbiturates may be habit forming. Pre-existing psychologic disturbances may be aggravated. Acquired sensitivity may result in allergic reactions. Safety in pregnancy has not been established. *PRECAUTIONS:* Use very cautiously with other sedative, hypnotic or narcotic agents. Use with caution in patients with acute hepatic disease, fever, hyperthyroidism, diabetes mellitus, severe anemia, and congestive heart failure. May impair alertness and coordination with increased accident risk. *ADVERSE REACTIONS:* Drowsiness, fatigue, vertigo, incoordination, tremor, muscle weakness, ataxia, hypotension, respiratory despression, delirium and coma. Dryness of nose, mouth, and throat, pupillary dilatation or blurred vision, urinary retention, abdominal pain, nausea, vomiting, diarrhea, and hypersensitivity reactions. Overdose or paradoxic reaction may cause excitation, insomnia, palpitation, tachycardia, convulsions and death. *DOSAGE:* Child 2-12 years: one WANS Children Supprette rectally every 6-8 hours. Infant 6 months-2 years: ½ dosage.

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antinauseant/antiemetic pyrilamine maleate 25 mg, sodium pentobarbital ½ gr (30 mg)

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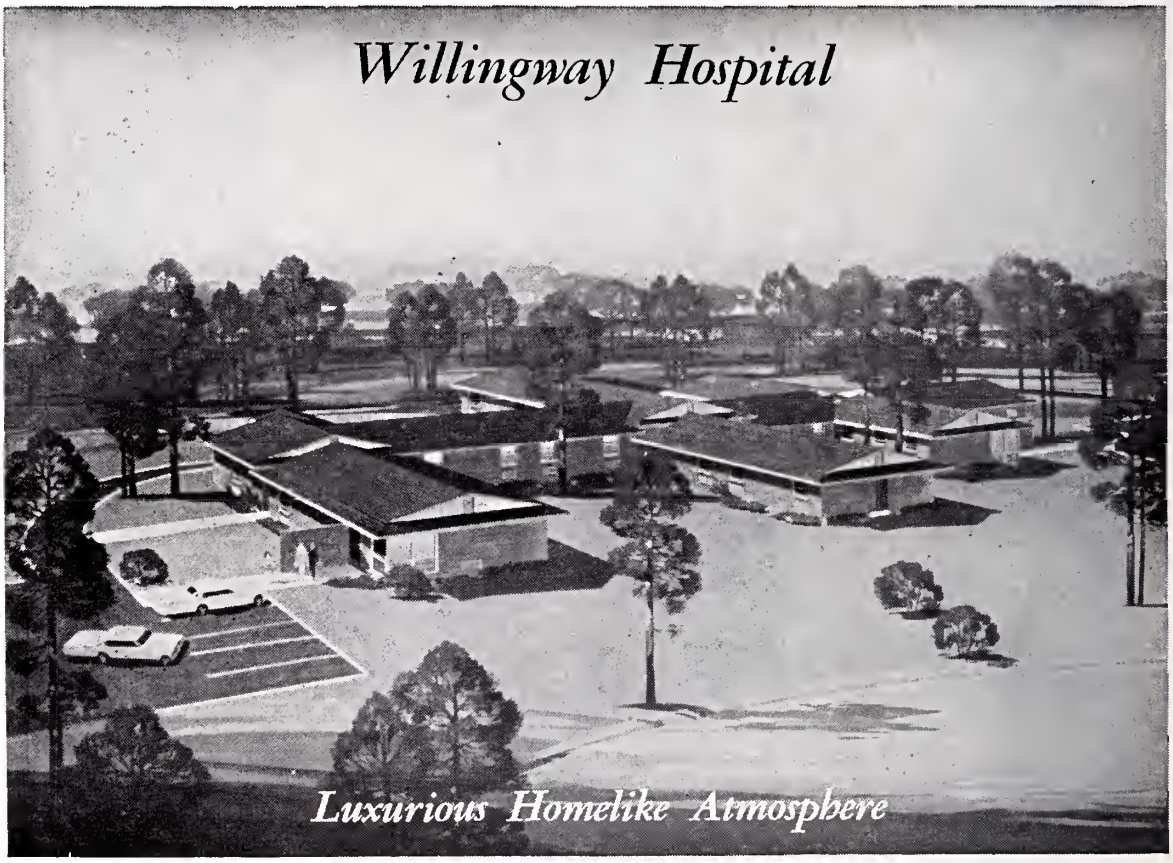

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Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or

Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic (hay fever) and vasomotor rhinitis, such as the common cold, seasonal allergies, sinusitis, otitis, conjunctivitis and otitis. In these diseases quickly reduces inflammation, nasal congestion and excessive upper respiratory secretions. Thus it provides relief from nasal stuffiness, congestion, drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the ethylenediamine class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of the drying and thickening effect on bronchial respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children.* In infants

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Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

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when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

Ⓒ III Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

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Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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The Upper Functional G.I. Disorder

The Pseudo-ulcer

Ulcer-like symptoms: no G.I. pathology

X-ray demonstrates normal stomach.

The patient is convinced he has an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses. Please consult the complete product information regarding precautions and adverse reactions.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders; clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W.B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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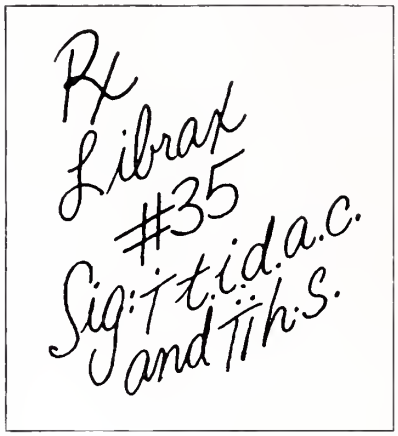
Please see summary of product information on following page.

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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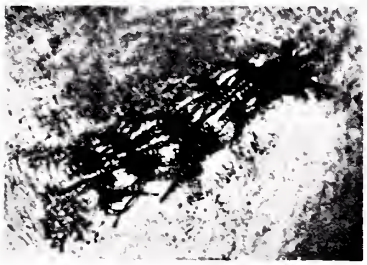

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Letters

Workmen's Compensation

To the Editor: For as long as I can remember, we have had a problem collecting a small percentage of Workman's Compensation claims, even when properly authorized and billed. In our office today, I counted 44 individual bills delinquent from two to eight months, totaling over $8,000.

This takes a substantial portion of the time of one office assistant who must pull the clinical records and ascertain that the bills have been properly submitted and then telephone throughout the state to various insurance companies and adjustors at long distance rates to follow-up on these delinquent accounts. Sometimes, we are told that this account has been closed out and our bill has been "overlooked". We are sometimes requested to resubmit a new bill.

I would be interested in hearing from any other members who feel that they have a similar significant problem in this regard. I would like to know if possible, the number of delinquencies over 60 days and the number over six months and the total dollar amount.

Edward J. Sullivan, M.D.
2545 Riverside Avenue
Jacksonville, Florida 32204

Medicaid

Editor's Note: The following letter to Dr. Morrow is in response to his article published in the August Journal entitled "The Prescribed Medication Program (Medicaid)," and is being published to illustrate two points. One, that the Journal attempts to present the truth, unbiased and revealing both sides of all problems Secondly, the last sentence is assumed by the editor to imply that "his own surgeon" *does not* operate for chronic appendicitis, for that is the philosophy in the hospital where the editor practices general surgery and is chairman of the Utilization Committee.

Dear Ed: You have joined a distinguished group (Osler, Oliver Wendell Holmes, Hippocrates) in breaking a lance on the windmills of poly-pharmacy, but our species, which I think of as Homo credens, not sapiens, believes in wizards. The doctor who prescribes for those who yearn for more pills, or shots will do better than the man who takes the time to try to educate the uninstructable.

In 1370 Chaucer's physician had the same problem giving every patient prescriptions and send them to his apothecary. "Each helped the other for to win, their friendship was not new to begin." Doctors then, as now, had overhead to meet; wives, children and in-laws to support, and could not afford not to give the patients the purges, pukes, and phlebotomies they believed in. Libman once told me that while he knew there was no chronic appendicitis, when he had a patient who had been told, or decided, he must have that disease, he sent him at once to his own surgeons — "Why let him go elsewhere to be swindled?"

Bill Dock
New York

Dr. Dock is a consultant in medicine at Kings County Hospital, Brooklyn; member of the Society for Clinical Investigation and Society for Experimental Biology and Medicine; member of the New York Academy of Medicine and best known for his work in electrocardiography and ballistocardiography.

H.R. 12053 Legislation

To the Editor: I am writing in response to Dr. Thad Moseley's column entitled, "Time to Think" on page 611 of the August issue of the *Journal of the Florida Medical Association*, and his assertion that legislation which I cosponsored, H.R. 12053, would regulate "medical services and physicians . . . as a public utility." I would take issue with Dr. Moseley's statement for several reasons.

H.R. 12053 was introduced by myself, Congressman Roy, and Congressman James Hastings as a discussion piece to replace legislation authorizing comprehensive health planning, regional medical programs, and Hill-Burton legislation, all of which expired on June 30, 1974. This bill included an admittedly controversial section which provided for states to conduct rate review of health care institutions in order to attempt to combat rapidly increasing costs of health care. In my introductory statement, I stated that "I do not anticipate that everybody will agree with all of what is proposed but hope, by putting forward a complete proposal, to engender a thorough debate of these issues so that the subcommittee may later rewrite the proposal as much as necessary to achieve the best possible approach to the problems of health service availability and cost which we all wish to solve". In H.R. 12053, for purposes of the proposed rate regulatory programs, health care providers were to include hospitals, nursing homes, community health care programs, home health agencies, and indirect suppliers of health services (such as medical laboratories, ambulance services, blood banks, and dental laboratories). Rate regulation was never intended, even in this discussion measure, to include direct providers of health services such as physicians and other health professionals. Certainly, physicians were not intended to be treated as "puhlic utilities."

On April 4, 1974, after several meetings with organizations representing health care providers and correspondence with other interested individuals, and before the Subcommittee scheduled hearings on "health planning" legislation, I introduced a revised measure, H.R. 13995, which among other things, deleted the provisions of H.R. 12053 which authorized rate regulatory programs.

After Subcommittee hearings, we began a lengthy consideration of the several proposals and the complex issues which had to be resolved, of which one was the issue of rate regulation. Testimony presented during the hearings convinced the Subcommittee that neither the States nor the Federal government are presently equipped with the necessary expertise to regulate institutional costs. As I stated earlier, it was never our intention to regulate the charges and fees of direct health services providers.

The Subcommittee reported bill, H.R. 16204, presently pending full Committee consideration, does provide for a review of both new and existing *institutional* health services and making findings as to the need for them by the State Health Agency. These findings would have no force in terms of closing those institutions which are found to be unnecessary, but would, it appears to me, provide valuable information as to the need to build additional facilities which would only add to the high costs of health care. I feel this is a reasonable compromise and in the best interest of the American people, particularly in these inflationary times.

Paul G. Rogers, M.C.
Chairman, Subcommittee on
Public Health & Environment
Washington, D.C.

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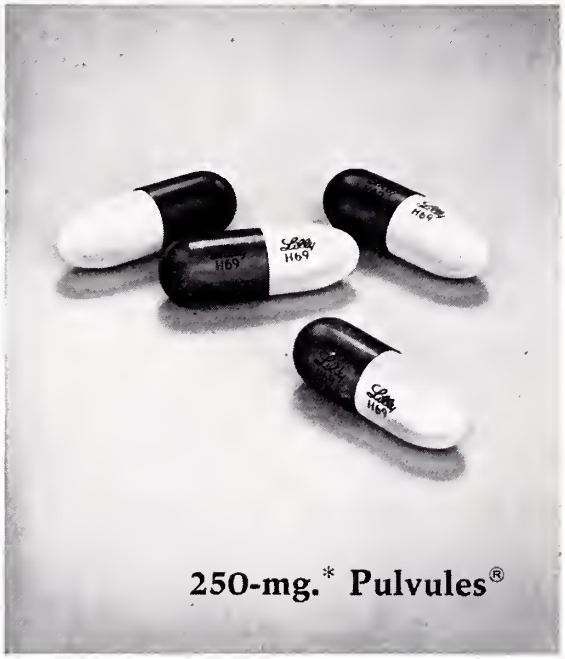

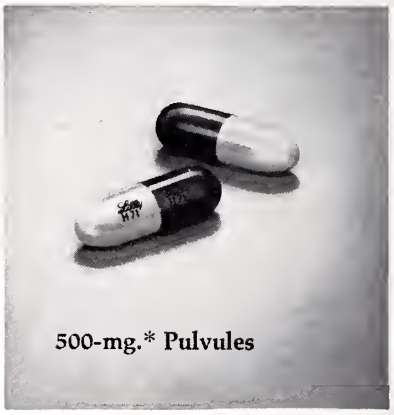

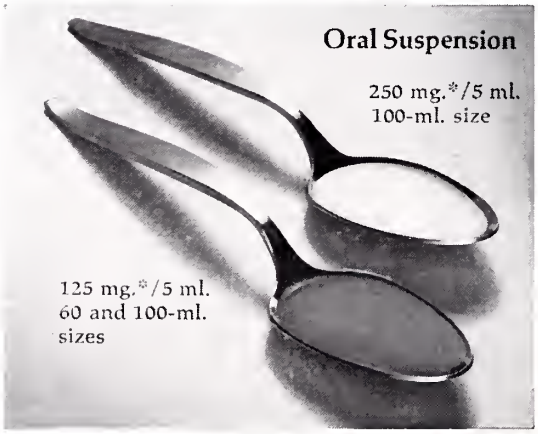

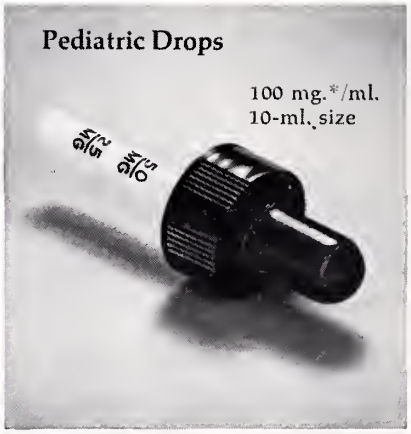

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

OCTOBER, 1974 • VOLUME 61 • NUMBER 10

Treatment of Medullary Carcinoma of the Thyroid Gland

HARRY J. TAMONEY JR., M.D.

Abstract: Medullary carcinoma of the thyroid gland is established as an important and distinct entity, unequivocally separable from other types of thyroid cancer. While not as lethal as anaplastic or undifferentiated cancer, it is considerably deadlier than the more commonly occurring papillary and follicular adenocarcinomas. Many comments about "aggressive treatment" have been advocated on the basis of historically reviewed experience, yet no exact, planned, "spelled out" operation has been reported for primary treatment of what is essentially a new disease. A concept of treatment in use is described. This is an extensive extirpative procedure with a low morbidity rate which includes all avenues of lymph node spread, and is designed to lower the current high and unacceptable mortality rate of medullary carcinoma of the thyroid gland.

For many years thyroid cancer has been classified into three principal groups, the larger including papillary and follicular adenocarcinomas and the smaller anaplastic or undifferentiated carcinomas. Anaplastic carcinomas previously had been considered incurable but apparent cures have been recognized. Histological research investigated why some patients with undifferentiated thyroid cancers had a better prognosis. Horn reported a small series of patients with such cancers in 1951.[1] In 1954 Brandenburg confirmed Horn's findings.[2] Hazard, Hawk and Crile in their classical study of 1959 identified the undifferentiated neoplasm with better prognosis as medullary thyroid carcinoma and were the first to document it as a separate, pathologic entity.[3] They emphasized the importance of the presence of amyloid in the stroma. Other investigators later confirmed that no other cancer of the thyroid had amyloid, and consequently the diagnosis of medullary cancer is unacceptable today without its identification.

Hazard, Hawk and Crile's initial report prompted others to review the files of patients with anaplastic carcinoma of the thyroid who had survived more than one year. Information from such retrospective studies has provided the bulk of knowledge concerning medullary carcinoma of the thyroid. Approximately 300 cases have been reported.

Incidence

In 1969 Williams grouped together six of the largest series of medullary carcinoma of the thyroid.[3-8] He collected 264 cases and found the incidence to be 8% of all thyroid cancers. Keynes in 1971 reported an incidence of 7.5% among 2,352 cases.[9] Perhaps a more realistic incidence would be approximately 10% or higher as undoubtedly many medullary cancers of the thyroid have been unrecognized.

Age and Sex

Medullary carcinoma of the thyroid usually affects adults and the majority of patients are in their 7th decade. The youngest reported patient was 13 years of age[10] and the oldest 82 years of age.[8]

Like all cancers of the thyroid there is a predilection for the female. In Ibanez' series of 53 patients, the incidence was equal in males and females.[8] In all other reports including Williams' the incidence was approximately three to one in favor of the female.

Pathology

These tumors are larger than papillary and follicular cancers. Lesions up to 13 cm in diameter have been reported[5] and it is not uncommon to find an 8 cm lesion. An important clinical feature is the stony hardness to palpation which distinguishes them from the usual soft, cystic or rubbery feeling of non-neoplastic goiters. On cross section a characteristic gritty sensation is felt similar to that of other organ cancers. Usually the color is grey-white but may be reddish brown as other thyroid cancers. The tumor is not encapsulated and arises with equal frequency from either lobe.

Microscopically the typical tumor is composed of sheets of cells having amyloid in the stroma. Although the diagnosis is unacceptable without identification of amyloid, this position could change in the future. Possibly the diagnosis is presently being excluded in those patients where either only small amounts of amyloid are secreted or scant amounts of tissue are available. There is much speculation about the source of amyloid. The earlier concept of Vassar[11] that it was an altered thyroglobulin has been replaced by the more tenable position that amyloid is manufactured by tumor cells per se.

Further investigation into histiogenesis has revealed that the cancer arises from parafollicular cells in contrast to papillary and follicular adenocarcinomas which arise from cells of the thyroid follicle. It has been postulated that these parafollicular cells are the same as C cells derived from the last or ultimobranchial pharyngeal pouch and which are the source of calcitonin production.

Spread of Tumor

Medullary cancer has a far greater propensity for earlier and more extensive cervical node involvement than other thyroid cancers. Increased involvement of paratracheal lymph nodes has also been realized as well as deeper penetration to nodes in the mediastinum. Experimental injection studies have shown abundant retrosternal lymphatic pathways from the thyroid gland to the mediastinum.[12] Autopsies have frequently revealed involved anterior mediastinal lymph nodes matted together into a large retrosternal mass (Fig. 1).

Distant metastases with no local recurrence or regional node involvement is uncommon. Therefore good primary control by total extirpation of disease in the neck and mediastinum should be a significant factor in improvement of survival rates. Table 1 reports results of treatment up to present. Approximately one third of patients died of medullary carcinoma of the thyroid gland. This is a high, and unacceptable, rate; yet optimism can be encouraged when it is realized that very few of these patients were treated for medullary cancer. Most had an erroneous initial diagnosis of anaplastic or undifferentiated thyroid cancer. Treatment was predicated on that basis. A multitude of modalities were employed including hormones,

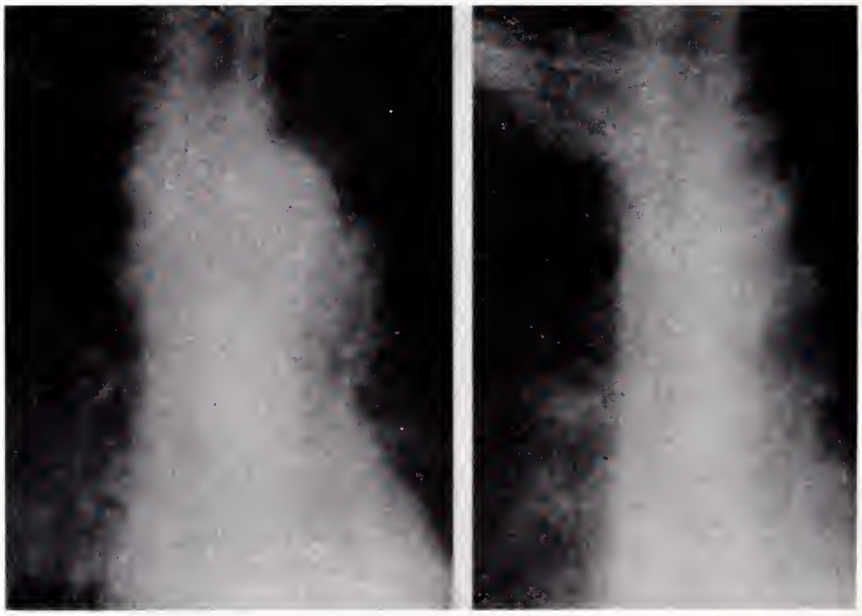

Fig. 1.—X-ray on left five years postoperative reveals large mediastinal mass caused by metastatic carcinoma of the thyroid. At right, x-ray four years after thyroidectomy and standard neck dissection reveals no disease.

chemicals, radiation and various thyroid excisions. Present knowledge should preclude all therapy but surgical extirpation.

Treatment

Table 2 suggests the minimal operative procedure. Total thyroidectomy is desirable. Intraglandular lymphatics are abundant and capable of transporting malignant cells to the opposite lobe. Such a rich complex of lymphatics exists that only rarely would a simple lobectomy offer a chance for cure. The incidence of bilateral lobe involvement is over 30%. Total thyroidectomy is acceptable in view of the high mortality from medullary thyroid cancer.

High priority is given to removal of nodes closest to the thyroid gland. Concentration on tissues behind the thyroid gland, medial to the carotids and adjacent to the trachea, is imperative. Dissection in continuity with wide removal of paratracheal nodes progresses along the recurrent laryngeal nerves into the mediastinum. A sternotomy should be performed for safe continuation of

TABLE 1.—REPORTED RESULTS OF TREATMENT.

Author	No.	NED 5 yrs.*	D of D
Woolner 1961	57	23*	14
Freeman & Lindsay 1965	33	19*	14
Davis 1967	15	3	12
Ibanez 1967	53	13	11
Casper 1968	10	4	4
Muller 1969	26	15	9
Williams 1969	14	8	4
	208	85	68

*not all 5 years

TABLE 2.—MINIMAL OPERATIVE PROCEDURE.

Total Thyroidectomy
Radical Neck Dissection
Sternotomy
Ant. Sup. Med. Node Diss.
Thymectomy

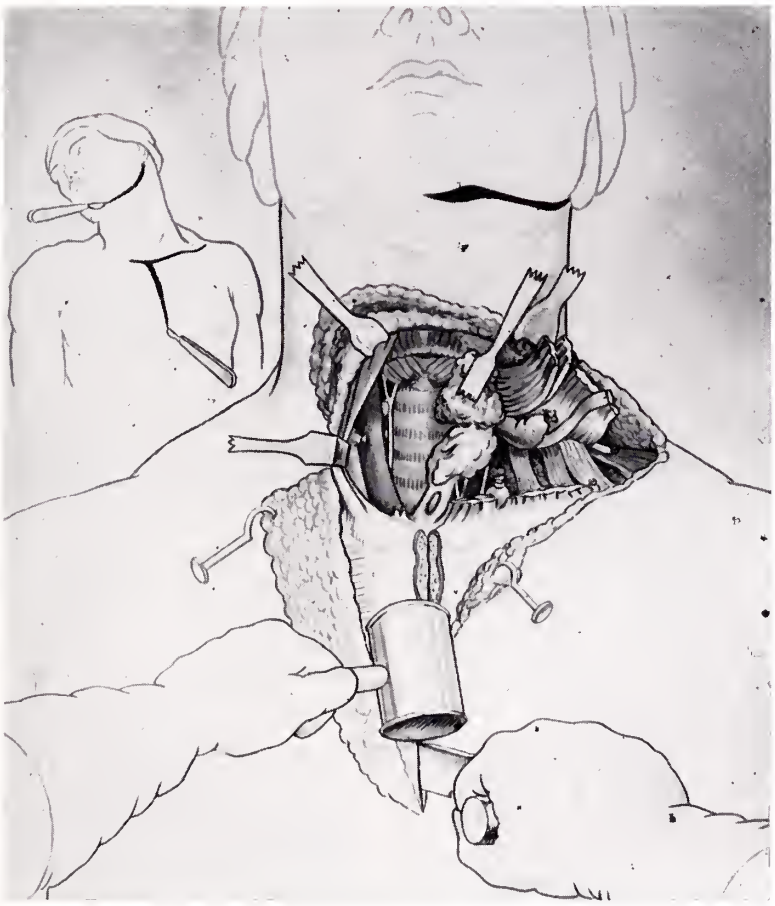

Fig. 2.—Facilitation of mediastinal exposure by splitting the sternum with Lebsche knife. Insert reveals transverse parallel radical neck incisions with vertical extension over sternum.

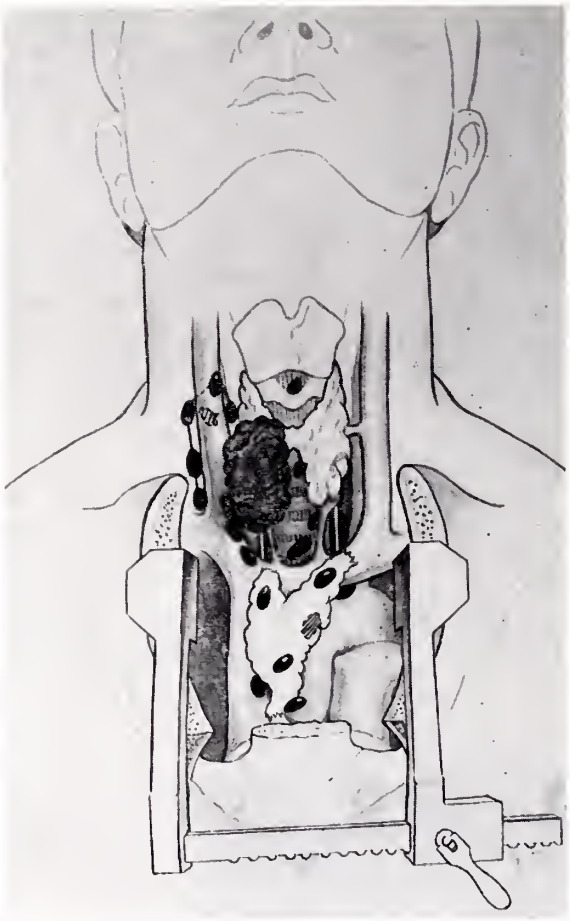

Fig. 3.—View of the anatomy demonstrating the depth of spread to mediastinal lymph nodes and the thymus gland.

this midline compartmental dissection which includes thymectomy and removal of all nodes down past the left innominate vein to the aortic arch.

Sternal splitting (Figs. 2 & 3) adds very little to the morbidity and to date has not affected operative mortality. This procedure has not been routinely advocated. There are instances of its use in cases of bulky substernal goiters as suggested in McClintock's report of nine cases with no mortality.[13] The occasional short fat-necked patient becomes an exceptionally acceptable candidate. Even Crile in his conservative thoughts on surgery for thyroid cancer comments that possibly the only indication for splitting the sternum would be for medullary cancer.[14]

When scarring from previous surgery makes secondary operations technically arduous, sternotomy with its generous exposure is most beneficial. It facilitates identification of recurrent laryngeal nerves in the mediastinum and permits dissection from below up to and through scarred areas.

Lateral dissection should be performed in continuity with the tumor. There is a distinct risk in waiting for clinical appearance of metastatic lymph nodes prior to performing node dissections.

In the presence of abundant clinically positive nodes, dissection should include the retropharyngeal lymph node area described by McCormack.[15] His concept and procedure may prove rewarding as such nodes may be the only ones left to harbor cancer.

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Dr. Tamoney, 745 Meadows Road, Boca Raton 33432.

ERRATUM

In the August issue of the Journal, on page 653, of Dr. Drohomer's article entitled "History of Volusia County Medical Society," the following correction is made:

Dr. A. M. McCarthy did not join the Volusia County Medical Society until 1946 and although he contributed much to the professional and political life of this community, he is NOT the McCarthy who with Dr. Maximilian Stern invented the "Stern-McCarthy" resectoscope."

Clinical Psychiatric Approach to Dementia

William E. Thornton, M.D. and Bonnie J. Pray (Thornton), R.N.

Abstract: The authors point to the need for an appropriate understanding of the significance of dementia as a presenting symptom. Emphasis is placed on it as a symptom complex rather than a specific and hopeless disease entity. The responsibility for a complete evaluation and the nature of that evaluation are described. The importance of family involvement is emphasized and encouraged.

Unfortunately, many of us practice psychiatry or psychiatric-oriented disciplines in communities where a neurologist is not available. This provides us with the responsibility for an appropriate clinical approach to the patient who presents with dementia. An appropriate approach should be based upon the knowledge that dementia is a symptom complex that may be approached from three fundamental aspects: (1) Dementia may represent a progressive and irreversible process of mental deterioration which is at best managed with behavioral control and eventually chronic nursing care; or (2) Dementia may represent a symptom of a reversible and definitely treatable organic disease process, or finally, (3) Dementia may represent a partial manifestation of a psychiatric illness, which is treatable.

The purpose of this paper is to specifically discuss the clinical approach to dementia. We will not become involved in nosology, but would strongly urge clinicians who treat dementia to obtain the Contemporary Neurology Series, Dementia, edited by Wells.[1] Additional references of a generalized nature are papers by Firestone,[2] Hughes,[3] Roth,[4,5] and the recent texts of Pearce and Miller,[6] and Busse.[7]

For our purposes, we define dementia as a spectrum of mental symptoms resulting from disease of man's cerebral hemispheres in adult life. This process is characterized by a progressive decline in intellectual function, failing judgment and impaired memory; a reduced capacity to employ mental mechanisms effectively for goal achievements. It is important to recognize that the spectrum of the symptom complex may range from bare discernibility to cerebral death.

Our experience is consistent with other clinicians who find that, with a careful history and a mental status examination, the patient who presents with mild to moderate dementia and whose history demonstrates initial and predominant psychiatric symptoms, i. e., affective disorders, paranoid delusions, and hallucinations, etc., is not likely to suffer from the progressive and irreversible dementing disease process. In this patient an appropriate psychopharmacological approach is indicated and is generally very helpful. The case of an anxious depression and an anxiety reaction in the geriatric patient with symptoms of mild dementia may be an exception, and chemotherapy is often either unrewarding or met with multiple frustration due to the patient's perplexing hypersensitivity to drug side effects. Time itself then becomes a therapeutic and diagnostic tool. Clearly in the individual whose illness is primarily psychiatric a failure to recognize and treat the disorder adequately and accordingly to consider the individual as primarily "demented" represents a potential tragedy. One wonders how many chronic geriatric care center patients who are receiving maintenance dosages of depressant tranquilizers would show marked improvement in behavior if instead they were placed on antidepressants. This question illustrates the too common existence of "depressive pseudo-dementia," an entity well discussed by Post[8] and a term which is literally descriptive of the clinical situation. The excellent studies by Roth also point to many of these differential psychiatric observations.[4,5] Chemical straightjackets often inappropriately serve to confirm the patients inabilities of goal achievement and thereby a false diagnostic conclusion. Our opinion is that clinical psychiatric reassessments of differential diagnoses and treatment are indicated in many geriatric patients.

In considering patients who present with symptoms of dementia, the differential diagnosis from other organic conditions is of paramount importance. According to Pearce and Miller,

treatable organic causes for dementia range from 8% to 15%, if an appropriate work-up is rendered.[6] The work-up calls for short-term hospitalization with a neurologic examination and these laboratory studies (and possible suggestive results): Complete blood count (anemia, macrocytosis, infections), sedimentation rate (vascular inflammatory disease), electrolytes (hyponatremia), urea nitrogen (azotemia), liver function tests (hepatic failure, Wilson's disease), blood glucose (hypo- and hyperglycemia), calcium, phosphorous, and alkaline phosphatase (hypo- and occasionally hyperparathyroidism), thyroid function studies (hypothyroidism), serology (CNS syphilis,) serum folate (folate deficiency), serum B_{12} (B_{12} deficiency and pernicious anemia), diurnal serum cortisols (for hypo- and hyperadrenalism), electroencephalogram (focal lesions or diffuse cortical dysfunction), brain scan (focal lesion), skull x-ray (focal lesion or calcium metabolic signs), RISA cisternography (normal or low pressure hydrocephalus), and an electrocardiogram with a long rhythm strip (significant arrhythmias). A pneumoencephalogram can be very useful if there is strong suspicion of hydrocephalus, and some workers feel it should be part of the standard dementia work-up.[9,10]

Testing and Family Involvement

The value of psychometric testing is generally believed to correlate with the examiners experience; however, a few basic Bender designs or drawings (reproductions of the face of a clock, a cube, etc.) are valued screening tools. The inability to recognize objects in the presence of normal visual acuity (visual or object agnosia) is a common finding in cerebral atrophy. As elaborate as the work-up might sound, all may be accomplished within a three to five day hospitalization. Depending on the size of the community, test results may require additional time for interpretation and the return of results from larger centers. These results need not prolong the patient's hospital time. We cannot deny the obvious costs of the work-up. We can only state our feeling that an 8-15% treatable cause may make the difference between medical completeness and possibly the basic deferment of reasonable responsibility. In actual fact, the clinician can only outline the clinical approach, its implications and his recommendations to the family; the ultimate decision is theirs.

Family involvement is believed to be a prerequisite to the clinical approach as well as to the patient's future welfare. We advise the family of the important diagnostic meaning of the patient's symptoms. The three fundamental aspects of dementia as previously described should be discussed before any work-up studies are commenced. Following an explanation of the purpose of a complete work-up we hope that the family's fears will be alleviated to the point that they will provide useful and important historical observations. The significance and consequence of initial and predominant historical symptoms have been well demonstrated, stressing the clinician's ability to make a differential diagnosis.

We find that an explanation of the evaluation, the meaning and goals of the specific tests, and an understanding of the results of those tests are extremely reassuring, especially to the patient's "nearest other person." Hopefully this knowledge will enable that person(s) to be more helpful, effective and calm in dealing with the practical problems at hand. Realistic planning in the event that there is an untreatable cause is imperative, and the knowledge that treatable causes have been excluded aids the family in reducing guilt and/or anxiety. An understanding of what is occurring leads to an open and bilateral medical communication that the family can readily comprehend and accept rather than the all too common "it's hardening of the arteries." The latter is felt to be a less rewarding approach for all concerned.

We have intentionally attempted to be brief and specific in our presentation concerning the appropriate neuropsychiatric approach to this poorly understood and often unrecognized subject. We feel that if our thoughts are considered the result should be families with enhanced understanding and comfort; also a rendering of fewer patients to inappropriate custodial servitude.

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5. Roth, Martin and Morrissey, J. D.: Problems in the Diagnosis and Classification of Mental Disorders in Old Age; with a Study of Case Material. J. Ment. Sci. 98:66-80. 1952.
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8. Post, F: The Clinical Psychiatry of Late Life, London, Pergamon Press, 1965.
9. Rice, E. and Gendelman, S.: Psychiatric Aspects of Normal Pressure Hydrocephalus. JAMA 223:409-412. 1973.
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Dr. Thornton, Naples Community Hospital, 848 First Avenue North, Naples 33940.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

OCTOBER

Common Allergic Diseases of Children, Oct. 5, Gainesville**

A Positive Approach to Cancer Diagnosis and Treatment, Oct. 5, Putnam Memorial Hospital, Palatka*

Emergency Medicine, Oct. 6-8, Sheraton Towers Hotel, Orlando**

Fundamental and Clinical Aspects of Internal Medicine, Oct. 6-19, Sheraton Four Ambassadors Hotel, Miami*

Twenty Third Annual Seminar, Florida Diabetes Association, Oct. 11-12, Disney World, Lake Buena Vista, Florida. For information: J. T. Blackburn, M.D., 1351 S. Hickory St., Melbourne 32901

Post-Doctoral Refresher Training Program for Foreign Medical Graduates, Oct. 14, 28 & July 17, 1975, Rosenstiel Medical Sciences Building, Miami*

Orthopaedics and Arthritis, Oct. 18-20, Americana Hotel, Miami Beach*

▶ American College of Gastroenterology, Oct. 20-23, Americana Hotel, Miami Beach. For information: Mr. Daniel Weiss, 299 Broadway, New York 10007

▶ American College of Surgeons, Clinical Congress, Oct. 21-25, Miami Beach. For information: C. Rollins Hanlon, M.D., 55 E. Erie St., Chicago 60611

Annual Postgraduate Gastroenterology, Oct. 24-26, Americana Hotel, Miami Beach*

Diagnosis and Surgical Management of Gastrointestinal Diseases in Children, Oct. 26, J. Hillis Miller Health Center, Gainesville**

Reconstruction in and About the Orbit, Oct. 25-26, Innshooke, Florida (Tampa area), University of Florida College of Medicine**

Intensive Colposcopy, Oct. 25-27, Sonesta Beach Hotel, Key Biscayne*

Courses of Instruction in Coronary Care, Oct. 28-Nov. 2, Jackson Memorial Hospital Coronary Care Unit, Miami*

▶ American Society of Therapeutic Radiologists, Oct. 30-Nov. 4, Sonesta Beach Hotel, Key Biscayne. For information: Sheila A. McGing, 20 N. Wacker Dr., Rm. 2920, Chicago 60606

NOVEMBER

Florida Society of Internal Medicine, Nov. 1-3, St. Lucie Hilton, Stuart, Florida. For information: Mrs. Wanda L. McDermon, Florida Society of Internal Medicine, P.O. Box 2411, Jacksonville, Florida 32203.

Tumors in Children, Nov. 2, J. Hillis Miller Health Center, Gainesville**

Pediatric Pre-Football Game Seminar, "Tumors in Childhood," Nov. 2, J. Hillis Miller Health Center, Gainesville**

▶ Interstate Postgraduate Medical Association of North America, Nov. 4-7, Diplomat Hotel, Hollywood. For information: Mr. Roy T. Ragatz, Box 1109, Madison, Wisc. 53701

Cardiorespiratory Problems in the Pediatric Patient, Nov. 9, University Hospital of Jacksonville Auditorium, Jacksonville**

Pediatric Pre-Football Game Seminar, "Cardiorespiratory Problems in the Pediatric Patient," Nov. 9, University Hospital of Jacksonville Auditorium, Jacksonville**

Hand Surgery—1974, Nov. 15-17, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Miami*

Courses of Instruction in Coronary Care, Nov. 11-16, Jackson Memorial Hospital Coronary Care Unit, Miami*

▶ American Association for Clinical Immunology and Allergy, Nov. 21-24, Pier 66, Ft. Lauderdale. For information: John L. Dewey, M.D., P.O. Box 912, DTS, Omaha, Nebraska 68101

Progress and Prospects in Health Care Distribution Systems, Nov. 25-27, Fontainebleau Hotel, Miami Beach*

Pediatric Hematology, Nov. 30, J. Hillis Miller Health Center, Gainesville**

Pediatric Pre-Football Game Seminar, "Pediatric Hematology," Nov 30, J. Hillis Miller Health Center, Gainesville**

DECEMBER

The Primary Physician Looks at Human Sexuality, Dec. 5-8, Sheraton Four Ambasadors Hotel, Miami*

"Changing Concepts in Infectious Diseases for Obstetrics & Gynecology," Dec. 5-6, Hilton Hotel, Gainesville**

Florida Society of Plastic & Reconstructive Surgeons winter meeting, Dec. 6-8, Guadalajara, Mexico. For information: Ian Matheson, M.D., 4600 N. Habana, Tampa 33614.

▶ Southern Surgical Association, Dec. 9-12, Boca Raton. For information: W. Dean Warren, M.D., 1364 Clifton Rd., N.E., Atlanta, Ga. 30322

Courses of Instruction in Coronary Care, Dec. 9-14, Jackson Memorial Hospital Coronary Care Unit, Miami*

13th Biennial Cardiovascular Seminar—"Tools and Techniques of the Practicing Cardiologist," Dec. 12-14, Sheraton Four Ambassadors Hotel, Miami. For information: Thomas J. Noto Jr., M.D., 5080 Biscayne Blvd, Miami 33137

Rational Management of Patients, Dec. 26-28, Clearwater. For information: Virginia A. Church, Ph.D., 710 Magnolia Dr., Clearwater, Fla. 33516

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▶ National meetings being beld in Florida.

JANUARY

12th Annual Postgraduate Seminar in Anesthesiology, Jan. 2-5, Hyatt House, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Rd., Miami Beach 33140

Pediatric Nephrology, Jan. 2-7, Americana Hotel, Miami Beach*

Complications in Anesthesiology, Jan. 3-5, Hyatt House, Miami Beach*

Neuro-Ophthalmology Seminar, Jan. 6-9, Doral Hotel, Miami Beach*

Topics in Clinical Pediatric Neurology, Jan. 9-11, Hyatt House, Miami Beach*

Infectious Diseases: Treatment & Prevention, Jan. 9-11, Hyatt House Hotel, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Pathology of the Oral Cavity & Its Management, Jan. 10-11, Fontainebleau Hotel, Miami Beach*

Courses of Instruction in Coronary Care, Jan. 13-18, Jackson Memorial Hospital, Miami*

9th Annual Postgraduate Seminar in Surgery, Jan. 16-18, Sutton Beach Hotel, Miami*

Emergency Cardiac Care, 1975, Jan. 16-18, Americana Hotel, Miami Beach. For information: Emergency Medical Services Symposia, Inc., 1200 N.W. 10th Ave., Miami 33136

Internal Medicine 1975, Jan. 19-24, Fontainebleau Hotel, Miami Beach*

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 22-25, Hyatt House, Miami Beach*

Diagnostic Radiology for the Emergency Department Physician, Jan. 26-31, Key Biscayne Hotel, Miami. For information: Richard L. Bean, M.D., Memorial Hospital of Jacksonville, Jacksonville

Human Disease Related to Food and Chemical Sensitivity, Jan. 29-31, Americana Hotel, Miami Beach*

FEBRUARY

Florida Midwinter Seminar in Ophthalmology & Otolaryngology, Feb. 3-8, Americana Hotel, Miami Beach*

Zoonoses in the Southeastern United States and Caribbean, Feb. 12-13, Florida Division of Health, Jacksonville. For information: Gerald L. Hoff, Ph.D., P.O. Box 210, Jacksonville 32201

First Annual Cancer Symposium, Feb. 19-22, Walt Disney World, Orlando. For information: Martha Bonar, 134 E. Colonial Dr., Orlando 32801

Courses of Instruction in Coronary Care, Feb. 17-22, Jackson Memorial Hospital, Miami*

The Diagnosis and Treatment of Acute and Chronic Respiratory Failure, Feb. 24-28, Miami Beach*

Thromboembolism: Diagnosis and Treatment, Feb. 27-Mar. 1, Doral Hotel, Miami Beach*

MARCH

3rd Annual Postgraduate Seminar in Emergency Medicine, March 5-9, Hyatt House, Miami Beach. For information: John Davison, M.D., 1200 N.W. 10th Ave., Miami 33136

Postgraduate Seminar in Neurology, March 10-14, Fontainebleau Hotel, Miami Beach*

Hormones and Cancer, March 10-14, Americana Hotel, Miami Beach*

Hypertension, Diabetes and Hyperlipidemia in Childhood, March 11-14, Americana Hotel, Miami Beach*

Clinical Radiology Seminar, March 18-22, Hyatt House, Miami Beach*

Seventh Teaching Conference in Clinical Cardiology, March 19-22, Sheraton Four Ambassadors Hotel, Miami*

Eighth Annual Instructional Course in Surgery of the Hand, March 21-23, University Hospital, Jacksonville. For information: Ira M. Dushoff, M.D., 824 Margaret St., Jacksonville 32204

Hypertension, Diuretics and Renal Disease, March 24-25, Sheraton Four Ambassadors Hotel, Miami*

APRIL

Courses of Instruction in Coronary Care, Apr. 14-19, Jackson Memorial Hospital, Miami*

Program for Foreign Medical Graduation, Apr. 28 & July 24, Sheraton Four Ambassadors Hotel, Miami Beach*

MAY

An Intensive Day in Intensive Care, May 3, VA Hospital, Miami*

Master Approach to Cardiovascular Problems, May 15-17, Walt Disney World, Orlando*

Notice to Subscribers

Increasing postage and publication costs have forced *The Journal* to raise subscription rates, effective January 1, 1975. On that date, single copies will go from 70¢ to $1.00. One-year subscriptions will increase from $7.00 to $10.00. Two- and three-year subscriptions will be available at $18.00 and $26.00. All subscriptions and renewals entered on and after January 1 will be billed at the new rate.

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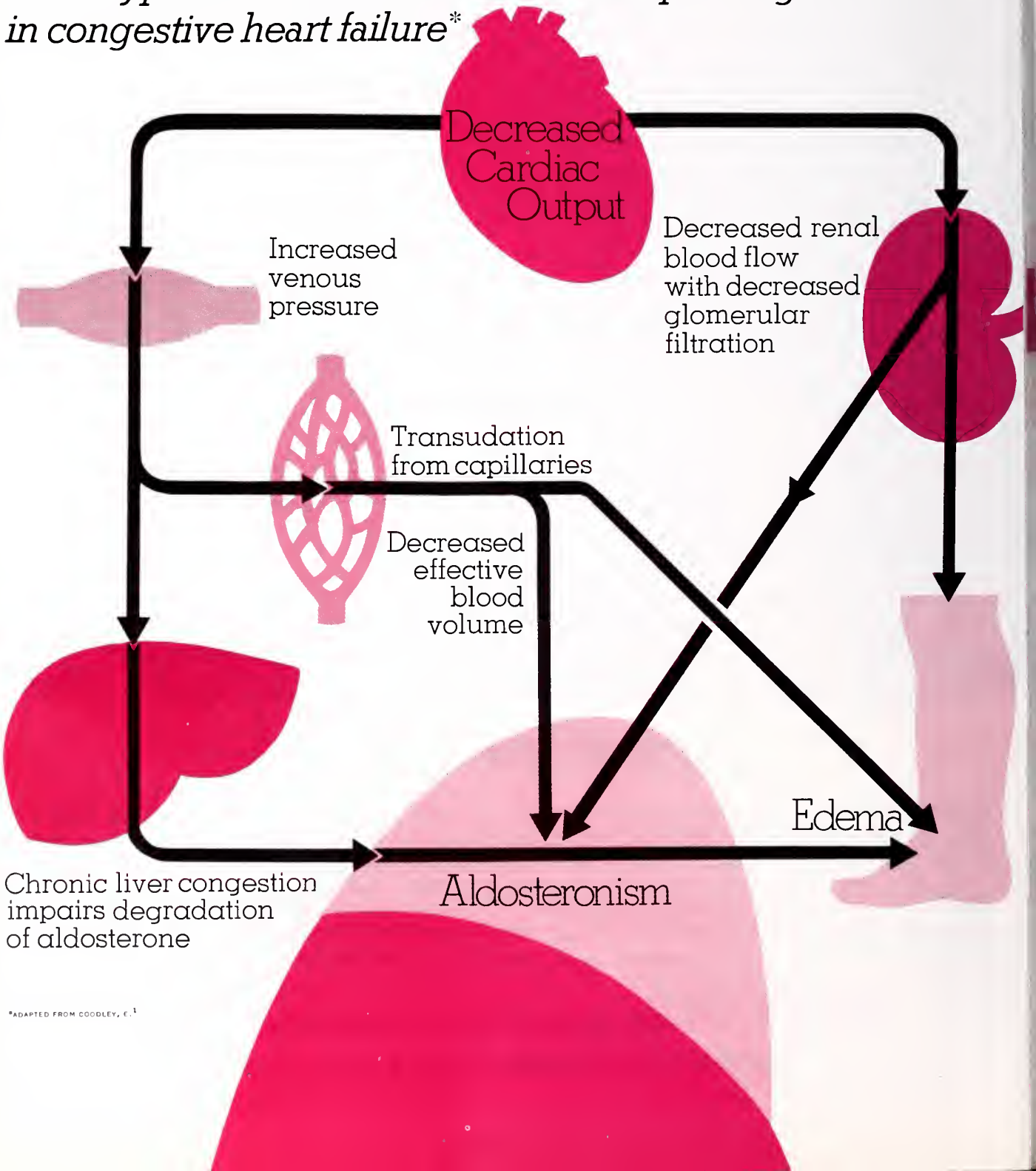

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- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
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3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E. Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P., Am. J. Med. 53:673-684 (Nov.) 1972

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The Role of the Detail Man

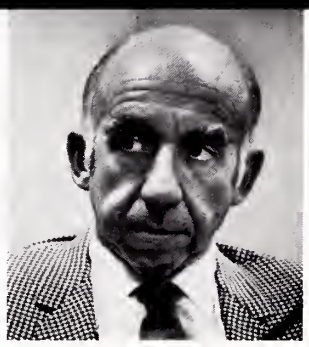
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairmai.
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoo on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

; He a Source of Information?

Yes, with certain reservations. he average sales representative as a great fund of information bout the drug products he is ponsible for. He is usually able to nswer most questions fully and ntelligently. He can also supply eprints of articles that contain a great deal of information. Here, oo, I exercise some caution. I usuilly accept most of the statements ind opinions that I find in the papers and studies which come rom the larger teaching facilities. t goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
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P·M·A

Special Articles

Twenty Five Years of Dedicated Service

In Jacksonville, on June 5, 1924, there first saw the light of day a boy destined one day to associate with more leaders of Florida medicine, probably had more to do with assisting the direction of organized medicine in Florida and who has this month completed a quarter of a century in serving the profession he has always loved. From a family of physicians, he was probably prompted to consider medicine as a vocation by an uncle, Dr. Robert L. Rhodes of Augusta, a classmate at Johns Hopkins of Dr. Ed Jelks. Perhaps his interest was also directed toward medicine by the proximity of his home to that of a beloved Jacksonville general practitioner, Dr. Silas M. Copeland. Growing up near a doctor's family, it is no surprise that as a teenager for a time he dreamed more about studying medicine than he did about one of the doctor's pretty daughters.

Graduating at 18 from Robert E. Lee High School in January, 1943, with the United States at war on two fronts, he entered the U.S. Army Parachute School in Fort Benning, Georgia. On completing this course he was ordered to the 502nd Parachute Infantry, 101st Airborne Division with whom he was awarded two battle stars in Europe.

Returning home and on to the University of Florida in Gainesville he transferred to Stetson where he graduated with an AB degree. He considered pursuing a doctorate in physics or medicine. Taking a breather, at the suggestion of his father, before continuing his education, he and his brother-in-law to be, Hal Copeland, applied for a job they were told about in public relations and legislation at a small office representing an association of physicians. Thinking the doctor's son would be given preference, he was surprised when offered the job and agreed to start to work in October 1949. So joining the FMA he served under Dr. Stuart Thompson, Managing Director, and Ernest Gibson as Assistant Director. With a meagre salary he nevertheless was successful the next year in persuading Mary Copeland to become his wife. His honeymoon was cut short and his dreams of going into medicine faded, when the following March he was recalled to active military duty where he served for a time in the office of the Surgeon General, Department of the Army, as an evacuation officer, IX Corps, and as administrative assistant to the Surgeon of the 8th Army and the United Nations Forces in Korea. He also served as aide-de-camp to the Chief Surgeon, Far East Command receiving an honorable discharge as a 1st lieutenant with two battle stars, and after nineteen months leave of absence, returned to FMA.

At the death of Dr. Thompson in 1953 Ernest Gibson was made Acting Managing Director but it soon became apparent that the younger man assigned to legislation and public relations had the qualifications to direct the activities of Florida medicine at that time and for years to come. So, in 1958 a new position, that of Executive Director was created. Because of his enthusiasm, energy and initiative, Harold Parham was elevated

When W. Harold Parham (center), Executive Vice President of FMA, received the degree of Doctor of Health Administration during the 100th Annual Meeting of the Association earlier this year, his bosses shared in the joy of the occasion. Flanking Dr. Parham are James W. Walker, M.D., Jacksonville, Secretary-Treasurer; and Joseph C. Von Thron, M.D., Cocoa Beach, then President.

to this role at the young age of 34. Opening the FMA's first official home, he saw the staff grow and he became involved in many activities. From 1965 to 1968 he was appointed secretary of Florida's Steering Committee on Health. He served six years on the original Executive Committee of the Florida Health Planning Council. He was a Director of the Florida Regional Medical Program during the years 1968 to 1971, being elected secretary and later treasurer during that time. He is the Executive Vice President of the Florida Medical Foundation. He is an affiliate member of the AMA and in the fifties was a member of its Public Relations Advisory Committee and currently serves on the Advisory Committee to the Executive Vice President of the American Medical Association. He is an associate member of the Southern Medical Association and a member of the American Association of Medical Executives having been elected their president in 1968.

From start to finish of each quarterly Board of Governors meeting, sitting beside the president, there is before him an ever-dwindling stack of manila folders, references, tho' seldom needed, to support his factual statements, to clarify the subject of discussion at the moment. Because of the demands on his voice he usually ends up very hoarse, especially should the meeting extend into the next day. Perhaps this may be partly due to the social activities of these meetings which he personally supervises, seeing that no trifle is overlooked but enjoying every minute. Conversely at each annual meeting opportunities to mix and mingle with FMA members are curtailed by the many responsibilities, programs and details he must oversee, so that unfortunately many people never get to know the real Harold. His outstanding management and business ability have been truly an asset to the Association and recognized by others where he serves as a corporate director or consultant, such as Director, Southeast First Bank of Jacksonville; Consultant to Harlan, Inc.; Chairman of the Board of Directors, Harlan-Med, Inc., and Secretary-Treasurer, Alpendorf, Inc.

There is an old French proverb that says the reputation of a man is like his shadow: It sometimes follows and sometimes precedes him, it is sometimes longer and sometimes shorter than his natural size. It seems that Harold's reputation could best be measured by those who know him best, the past presidents of the FMA. His position gives him the opportunity to associate with and become a close friend to these outstanding Florida physicians, each one of whom in his presidential address has given him credit for much of the progress attained in the preceding year. In 1962, Carnes Harvard of Brooksville compared him to Johnny Unitas when he said, "(his) smart quarterbacking . . . . has helped us out of many close spots." Described as our superb executive director by Sam Day in 1965; Dean Steward, in 1968, said, "Harold Parham and his staff formed the connecting thread that links together the activities of the FMA year in and year out." Last year, Bill Dean said that Harold thought more like a doctor than many doctors and at the annual meeting this year, before a surprised House of Delegates, at unprecedented ceremonies, the top medical education officials of the University of Florida, University of South Florida and the University of Miami, appearing in full academic regalia, joined to confer upon Harold the degree of Doctor of Health Administration, *honoris causa,* complimenting him, "as a leader of the highest order and as an administrator who has made significant contributions to the public health having spent his entire career in the service of the medical profession." At the presentation Dr. Ackell went on to say, "his responsibilities with the Florida Medical Association have included distinguished liaison work with local, state and federal governments discharging these responsibilities in a courageous, dedicated, creative and highly effective manner. His continuing commitment to working for the medical profession has endeared him to physicians throughout the state." Joe Von Thron, in his president's page in April of this year, said, "His leadership and effective work are widely acknowledged, magnifying the image of the president without ever detracting from the honor bestowed upon the president, he emphasizes the strength of the president by filling the void created by any weakness. He quietly and capably provides the continuity and stability required for the ongoing work of FMA."

And so, although it's not exactly the type of title that he started out to win, he has been awarded the coveted degree and for his dedicated years of service deserves to be addressed as Doctor Harold Parham. The Journal wishes him, Mary, and their children, Mary and Will, many more years of health, happiness and success in his chosen profession.

C.M.C.

The Physician's Assistant

Gregory R. Schott

The Physician's Assistant is a relatively new health care professional, the first graduate (Duke Program) appearing on the scene in 1967. The physician and the physician's assistant are certified, usually by the State Board of Medical Examiners, to work together as a team in the delivery of high quality medical care. In Florida, a physician may employ no more than two assistants due to the fact that he is responsible for the assistant and his work and must be available for consultation over matters concerning patient care.

Students are selected from many different backgrounds including clinical experience with direct patient contact and bachelor's degrees with little clinical experience. There are also many veterans of the Viet Nam War, and medics and corpsmen with independent combat service in the field.

The various training programs vary considerably in content and points of emphasis, but basically seek an educationally appropriate mix of didactic courses and clinical experiences. The only program in Florida is based in Gainesville under the direction of Richard A. Henry, M.D., and is a combined effort by the Santa Fe Community College, which is responsible primarily for the didactic portion of the program, Shands Teaching Hospital and Clinics and the Gainesville Veterans Administration Hospital which provide the various clinical experiences.

The student receives a wide scope of basic background in anatomy and physiology, pharmacology, biochemistry, medical microbiology, physics, and medical science of disease processes. Due to the relatively short period of training, he is exposed to a maximal amount of material in a minimal amount of time.

The student receives intense training in physical diagnosis, and recognition and interpretation of abnormal physical findings. Clinical experiences include rotations in the infectious disease service, general medicine wards, and surgical services including general, orthopedic and plastic. He is constantly supervised by interns, residents, and attending physicians. His function varies. On all rotations, the student performs the history and physical examination. The interns on the service also work up the patient and the patient is presented to the attending physician by the intern or the physician's assistant student. Mechanical tasks comprise some of the clinical training. These include WBC's, RBC's, differentials, urinalysis, and gram stains. Clinical procedures occasionally delegated to the physician's assistant student include lumbar puncture, thoracentesis; paracentesis, EKG's, and obtaining blood cultures.

In private practice the necessary relationship between a physician and a physician's assistant is one conducive to learning and understanding on the part of both. Together, they increase the quantity and quality of medical care by proper delineation of various tasks and responsibilities. For example, the P.A. might perform the initial history and physical on a new patient, order preliminary tests and present the pertinent findings to his physician-employer. The P.A. may also follow and monitor patients with chronic diseases, make hospital rounds, nursing home rounds, and house calls. The level at which he functions depends upon the competence he displays and the confidence earned from his physician-employer.

Experience shows a high degree of acceptance of the P.A. by patients. This can be maintained as long as the conducts himself in the highly professional manner in which he has been trained.

It is conceivable that the P.A. would have such an effect on the private practice setting that the physician would have more time to spend with his family, see more patients, and add income to the practice. These should be considered as assets along with increasing the pleasure of the practice of medicine.

For some time there has been a need for a health care professional who has the ability to extend the hand of the physician to more patients with the quality of medical care he is capable of giving. It is my belief that the physician's assistant can help him do this.

▶ Mr. Schott, 3301—11C Rocky Point Road, Gainesville 32608.

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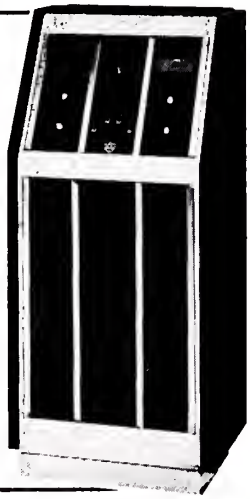

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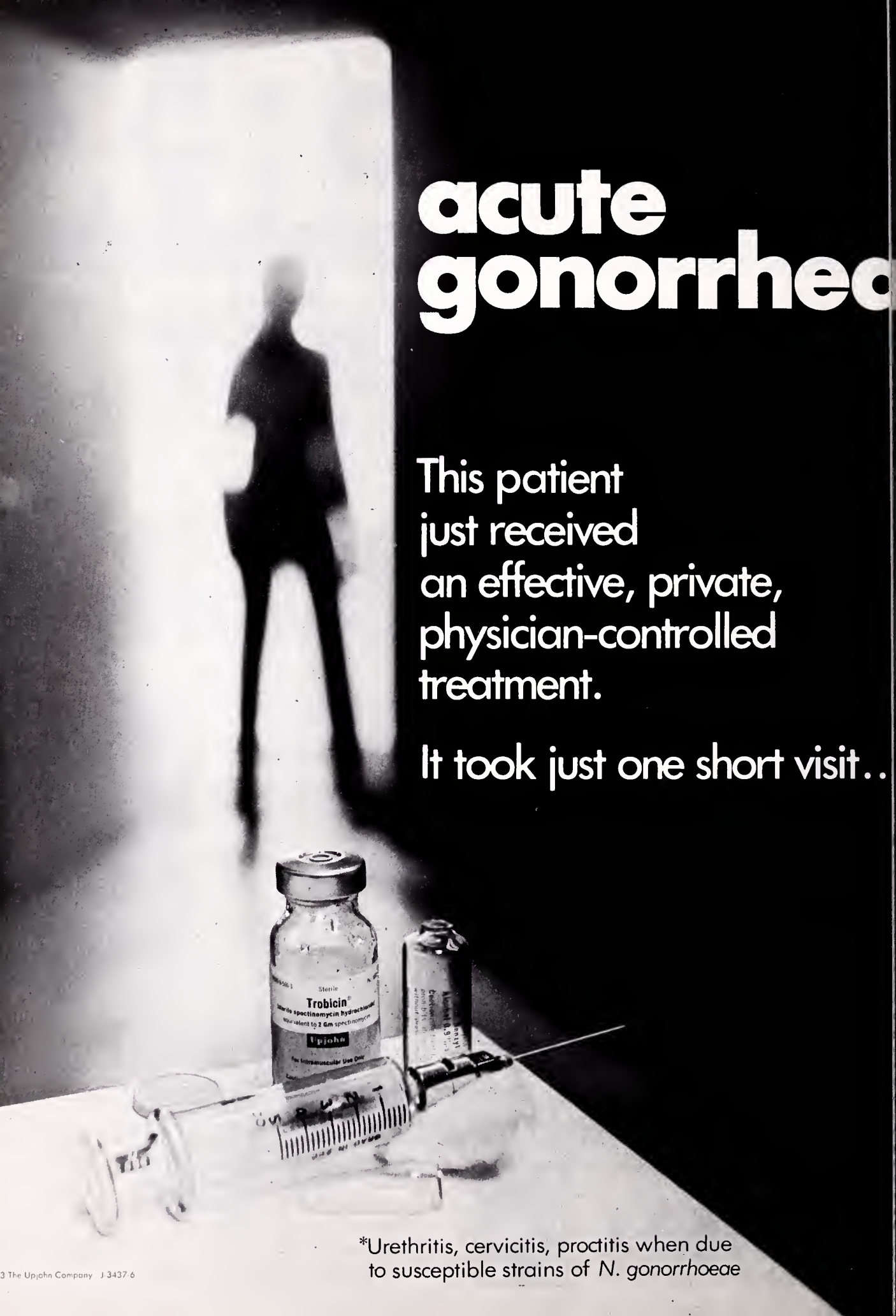
acute gonorrhea

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit..



*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

3 The Upjohn Company J-3437-6

Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly[1]; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

.and Trobicin® 2 gm and 4 gm vials
sterile spectinomycin hydrochloride

rile Trobicin
ile Trobicin (spectinomycin hydrochloride) or Intromusculor Injection:
m vials contoining 5 ml when reconstituted ı diluent.
m vials containing 10 ml when reconstituted ı diluent.
aminocyclitol antibiotic active *in vitro* against st strains of *Neisserio gonorrhoeoe* (MIC 7.5 20 mcg/ml). Definitive *in vitro* studies have wn no cross resistance of *N. gonorrhoeae* ween spectinomycin and penicillin.

lications: Acute gonorrheal urethritis l proctitis in the male and acute gonorrheal vicitis and proctitis in the female when due usceptible strains of *N. gonorrhoeae*.

ntraindications: Contraindicated in pa-its previously found hypersensitive to spec-mycin.

arnings: Not indicated for the treatment of hilis. Antibiotics used to treat gonorrheo y mask or delay the symptoms of incubating hilis. Patients should be carefully examined l monthly serological follow-up for at least nonths should be instituted if the diagnosis of syphilis is suspected.
Sofety for use in infonts, children ond pregnant women hos not been estoblished.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeoe*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C ond use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for o 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for o 4 gram dose.

How supplied: *Vials, 2 ond 4 groms—with ompoule of Bocteriostotic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

or patients with gonorrheal proctitis and for patients in geographic areas where antibiotic sistance is known to be prevalent, initial treatment with 4 grams is preferred.

anavac

anavac

The gentle evacuant that cleans the bowel and diverticuli.

Anavac Tablets contain:
Sodium Lauryl Sulfate...25 Mg.
1,8 Dihydroxyanthraquinone
.....75 Mg.
(Danthron)

Action and Uses: Anavac is a gentle evacuant that cleans the bowel and reduces the lytic or digestant action when it comes in contact with the anal skin. The sodium lauryl sulfate seems to gently cleanse the diverticuli by detergent properties. Anavac improves the muscle tone of the flaccid large bowel by gentle peristalic stimulation...accomplished (through the blood stream) by impulses at the Meissner Plexus of the colon. Since the Danthron bypasses most of the small bowel, there is no interference with digestion or fat-soluble vitamin absorption. Anavac is non-cumulative and non-toxic. The sodium lauryl sulfate seems to reduce the overstimulating effects of Danthron.

Administration and Dosage: Adults: one or two tablets after the evening meal with a full glass of water. Children under 12: one-half tablet with fluid after evening meal

Side Effects: May produce a discoloration of the urine. This is of no clinical significance. May appear in milk of lactating mothers.

Precautions: Frequent or prolonged use may result in dependence on laxatives.

Contraindications: Should not be used when nausea, vomiting, abdominal pain or other symptoms of appendicitis are present.

How Supplied: Bottles of 100 and 1000 orange, coated tablets

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Lenexa, Kansas 66215
(913) 888-8168

DOUGLAS PHARMACAL INDUSTRIES, INC.

Rondomycin®

(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in tibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults – 600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children – 3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

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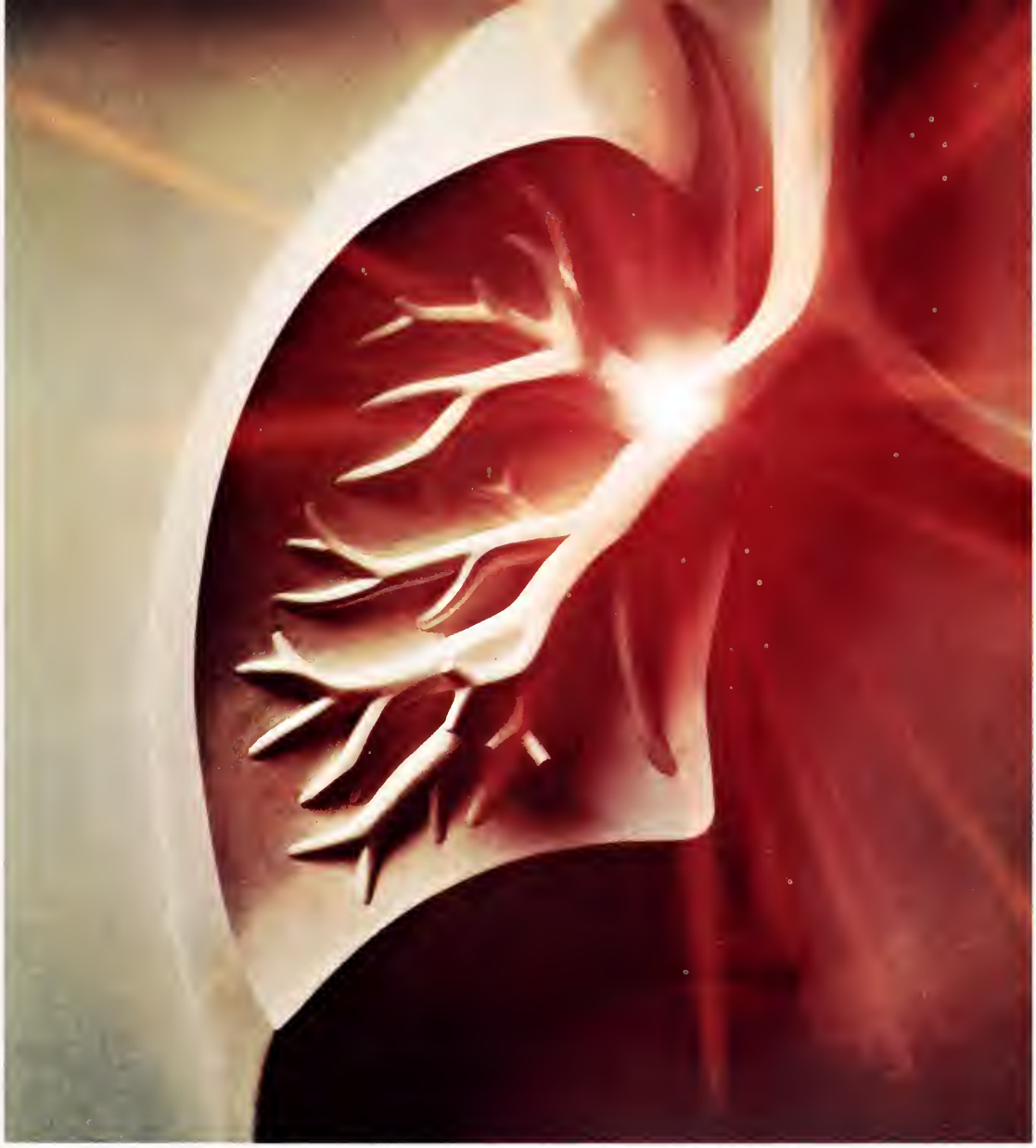


When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

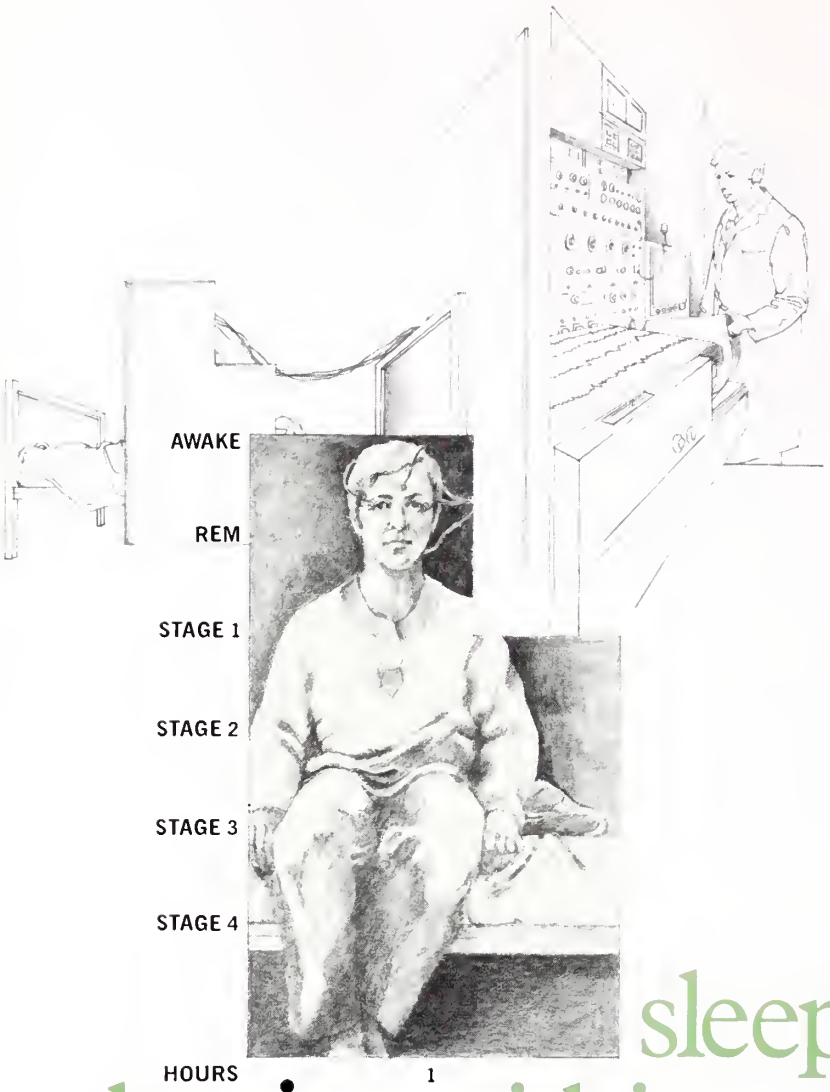
Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

Studies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains ore known to be resistont, routine sensitivity testing is recommended.



sleep begins within 17 minutes, on average ...

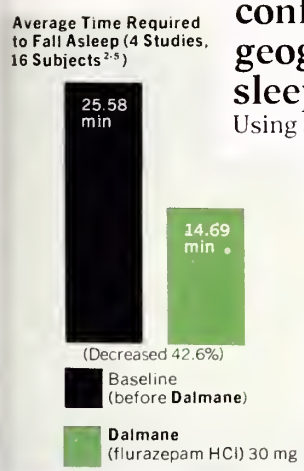
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently** – both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

KEEP THE HYPERTENSIVE PATIENT ON THERAPY
KEEP THERAPY SIMPLE WITH
DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

No potassium supplements
No special K^+ rich diets
Just 'Dyazide' once daily or twice daily

Studies have demonstrated that two prime reasons patients drop out of hypertensive therapy are: (1) the patient failed to understand directions, and (2) the regimen was overly complicated.* Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

*E.D. Freis: The Modern Management of Hypertension, V.A. Information Bulletin, 11-35.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP

Editorial

Medicaid—After Two Years

MATTHEW E. MORROW, M.D.

It was in October of 1972 that I agreed to come to the Division of Family Services as their Chief Medical Consultant. The month prior to that I had had the privilege of appearing on a panel at the Health and Rehabilitative Services' Conference for Physicians and Dentists in Tampa with Phillip Hampton who inspired my first editorial on Medicaid which appeared in this Journal in January 1973. Dr. Hampton's always clever and gloriously delivered remarks at that time were on Faith, Hope, and Charity.

Now Faith and Hope are both paradoxical things. Hope is neither passive waiting nor is it the unrealistic forcing of circumstances that cannot occur while the paradox of faith is the certainty of the uncertain. For those of you who are interested, a more elaborate explanation can be found in Erich Fromm's "The Revolution of Hope." (Harper and Row)

The word Charity comes from the Latin *Caritas* — dearness, affection, high regard, and has come to mean love; benevolence; that disposition of the heart which inclines men to think favorably of their fellowmen, and to do them good; liberality to the poor, consisting in giving money as benefaction, or in free services to relieve them in distress, etc. — (Webster). Agape is probably closer to the original and the truth — whatever that is.

How then did Charity become a responsibility of the State — the Government? Historically, of course, it began during the reign of Good Queen Bess who lovingly removed as many Catholic heads as Bloody Mary had claimed protestant bodies. However, when all the arguments of individualism against collectivism tumble with one emotionally toned picture of hunger or deprivation, human suffering or the disadvantaged poor even the conscience of the conservative is loath to murmur against governmental intervention.

But here we are today with about 175 million dollars allocated for medical services for Florida's indigent population and an ever increasing bureaucracy that has very little real medical knowledge to manage it. Thus my major concern has become the lack of adequate medical representation in Tallahassee in planning, management, and evaluation of all systems involved with health care, and, because of this, I recently urged the Governor to appoint a physician to his cabinet or at least appoint eight or ten physicians throughout the state to act as his advisors. Until we are better represented in the Capitol the public, through their political representatives, will have to continue making medical care decisions without adequate professional guidance.

It is my opinion that the responsibility for this enigma cannot be entirely laid on Government's shoulders; however, for all too often there is a lack of cooperative effort on the part of organized medicine in helping solve some of the health care problems that have become the responsibility of the state. Preservation of the profession without change or interference apparently is considered more important than the delivery of health care and herein lies our third paradox. How can the profession stand still and preserve its integrity while refusing to recognize its very reason for being? Is it because "the heart has its reasons that reason knows nothing of," as Pascal would have us think?

In *Atlas Shrugged,* Dr. Henderson, a distinguished brain surgeon, depressed about socialization of medicine in his country, says: "I observed that in all the discussions that preceded the enslavement of medicine, men discussed everything

— except the desires of the doctors. Men considered only the 'welfare' of the patients, with no thought for those who were to provide it. That a doctor should have any right, desire, or choice in the matter was regarded as irrelevant selfishness . . . ."

I have remained a free agent as a medical consultant to the Government in order to serve my fellow doctors as unencumbered of political or bureaucratic control as possible, but then maybe Gerry Schiebler is correct in feeling that therein lies also my weakness. I have openly and constantly sought help and cooperation from the Florida Medical Association in doing the best possible job for you, the state, and the poor who need medical help in a most medically unpopular position. Their response has been at best, courteous — at worst, none at all.

But to get to the point. If we as doctors are to accomplish anything worthwhile for our society and the society of the future we can not afford to linger further at the open door like Kafka's old man awaiting bureaucratic orders to enter. The act of liberation can only be accomplished by making our *own* door and boldly entering for the good of the profession and the tremendous work that it is expected to do. Perhaps Phillip Hampton has been right all along and Medicaid should be separated from welfare and under the direction of a physician. Perhaps *you*, with the blessings of organized medicine, should apply for the job!

▶ Dr. Morrow, 107 River Road, Orange Park 32073.

Important Notice to Authors

Beginning with the January 1975 issue, *The Journal of the Florida Medical Association* will begin a gradual conversion from the United States Customary to the Metric System of Weights and Measures.

In all manuscripts published in 1975, weights and measures will be quoted in both terms with the metric figure used first and the U.S. Customary equivalent following in parentheses. Example:

. . . an incision 10.16 cm. (four inches) long . . .

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It will be the responsibility of each author to see to it that his manuscript contains the proper metric measurements.

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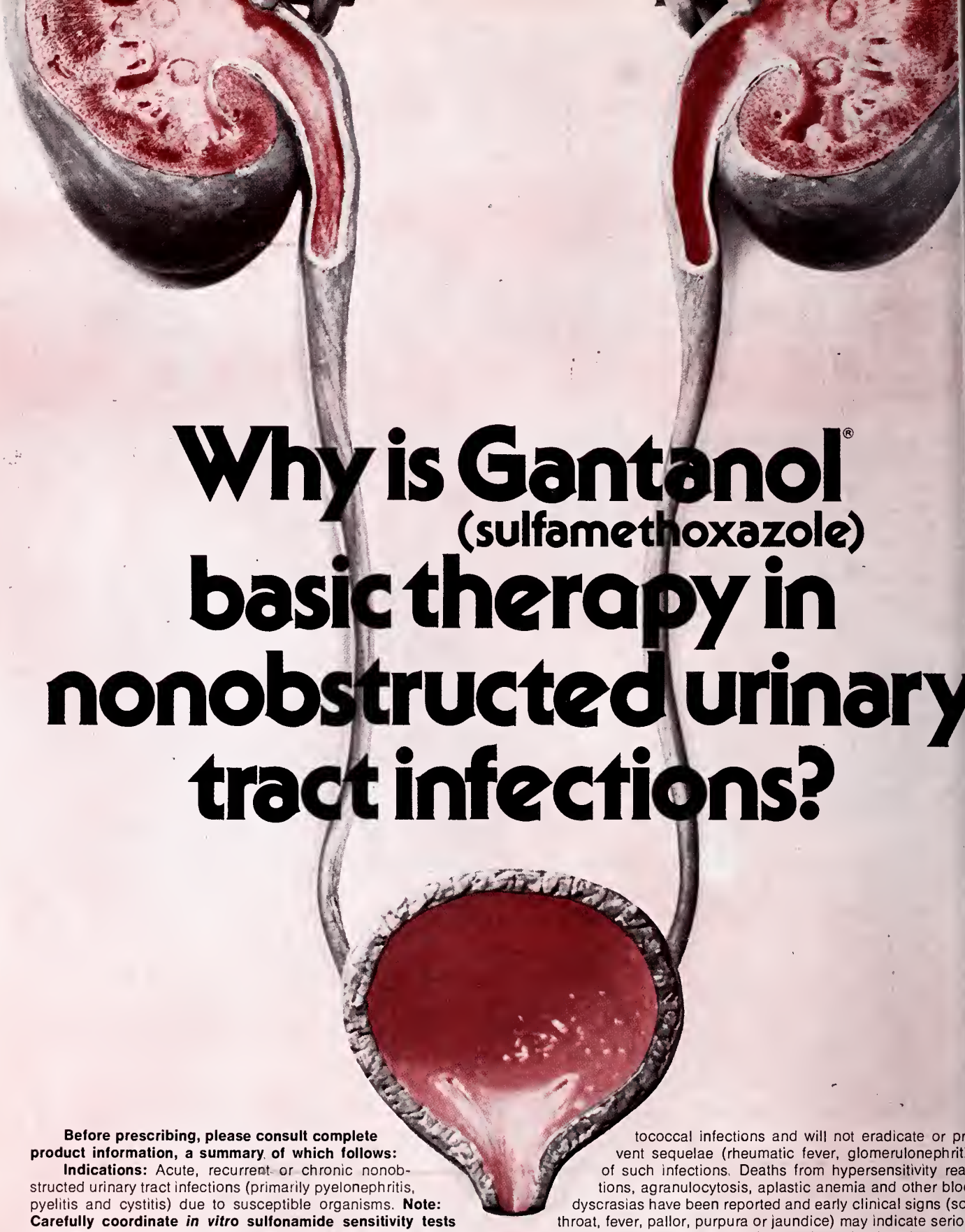

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Medical News

Journal Wins Award in Contest

The Journal of the Florida Medical Association won one of the top awards in the 1974 magazine contest sponsored by the Florida Magazine Association.

The Centennial Issue of *The Journal,* which was published in January 1974, was cited as first place winner for general excellence among publications of nonprofit associations with less than 20,000 circulation. *The Journal's* score of 95 out of a possible 100 nosed out an entry of *The Florida Bar Journal* by one point.

The Journal also received a Certificate of Merit in four-color cover judging for its May 1974 issue which showed a sunset on Sanibel Island.

Edward D. Hagan, Executive Editor of *The Journal,* accepted the citations at an awards banquet held in conjunction with the 22nd Annual Meeting of the Florida Magazine Association at Orlando in August.

Naval Aviation Museum to be Dedicated

Naval flight surgeons and aviation medical examiners of the past who are not now on active duty are invited and encouraged to submit material of historical interest to the new Naval Aviation Museum, N.A.S., Pensacola. Vice Admiral Chris Cagle, Chief of Naval Education and Training has allotted an important section for the display of aviation medicine's achievements in a beautiful new building to be dedicated in a few months.

All these developments have been brought about by nonappropriated funds. Physicians who have Navy backgrounds are invited to support this program by contributions of cash, equipment, important souvenirs, anecdotes, factual accounts of unusual experiences, achievements, innovations, devices —anything that will add to the exhibits and be of public interest.

Contributions may be sent to Captain Grover Walker, Officer in Charge, Naval Aviation Museum, N.A.S., Pensacola, Florida.

1,700 Apply for Exam

More than 1,700 physicians have applied to take the next examination of the American Board of Family Practice.

Board President Arthur Nelson, M.D., attributes the heavy registration to an increase in residency graduates and an apparent "recognition on the part of the Academy of Family Physicians members that board certification will affect their future."

Since the first family practice examinations in 1970, more than 5,800 family doctors have been certified.

Everybody's happy as Gov. Askew signs into law a bill providing $1.5 million during this fiscal year for support of family practice residency programs in Florida. The money will be channeled through the Community Hospital Education Council. With the Governor are (left to right): Edward G. Haskell, M.D., Tallahassee; Mr. Donald S. Fraser Jr., Director of FMA's Department of Public Affairs; Joseph P. Hendrix, M.D., of Port St. Joe, President of the Florida Academy of Family Physicians; Rep. Carroll Webb of Tallahassee; Harry W. Barrick, M.D., Director of the Family Practice Residency Program at Tallahassee Memorial Hospital; and Mr. Robert Davidge, Assistant Administrator of the hospital.

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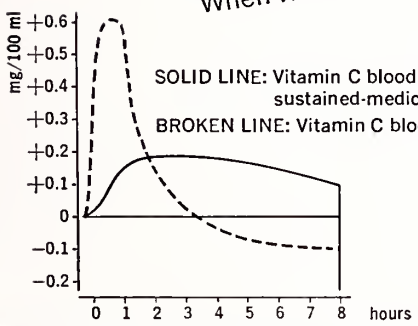

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[1] Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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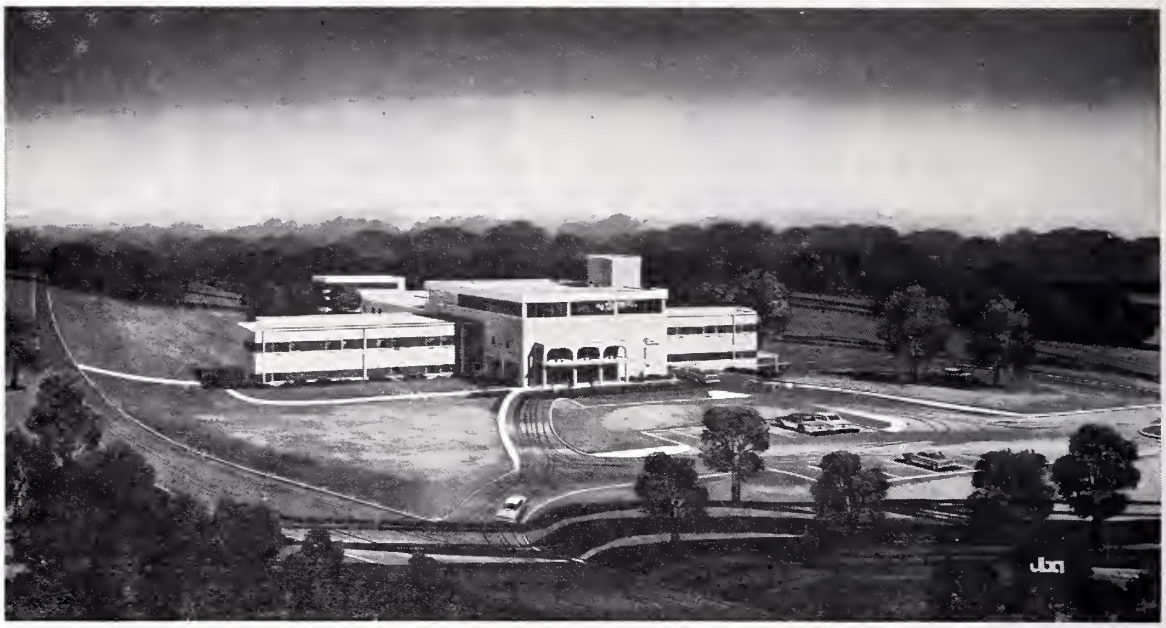

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PSYCHIATRIST for hospital and office practice in Florida's most prosperous city. Seven psychiatrists will welcome you. New 75-bed hospital underway. Office space available. Contact Robert G. Head, M.D., 1630-A North Plaza Dr., Tallahassee, Florida 32303.

OPHTHALMOLOGIST WANTED: Attractive opportunity in north central Florida. Community has well equipped, new 128-bed hospital and does not currently have an ophthalmologist. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

GENERAL SURGEON: Needed by expanding thirteen man group, located in beautiful Gulf Coast city, northwest Florida. Guaranteed salary, expenses paid during two year associateship leading to full partnership. New hospital just opened; new clinic building on drawing boards. Send credentials to Administrator, P.O. Drawer M-M, Fort Walton Beach, Florida 32548. Phone (904) 243-0223.

INTERNIST: Growing multi-specialty partnership in beautiful northwest Gulf Coast city. Needs U. S. trained board certified or eligible internist to join two man department. Guaranteed income plus percentage; all practice expenses paid. New 235-bed hospital just opened; new clinic building planned. Contact R. D. Riggenbach, M.D., P.O. Drawer M-M, Fort Walton Beach, Florida 32548. Phone (904) 243-7641.

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INTERNIST: Starting practice in growing community with new hospital in Jacksonville area seeks another as associate or partner. Write C-654, P. O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED ELIGIBLE INTERNISTS, prefer recent sub-specialty training in rheumatology, nephrology, hematology, 26 MD multispecialty group. Reply to Administration, Palm Beach Medical Group, 705 North Olive Avenue, West Palm Beach, Florida 33401.

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WANTED: SEMI-RETIRED SURGEON to assist in O.R., make rounds, apply casts, cover E.R. on alternating weekends. Call (305) 373-8333.

Miscellaneous

Family Practitioner, Otolaryngologist, Pediatrician, Internist-Rheumatologist, and Internist-Pulmonary Disease needed for outstanding practice opportunities. Forty-six physician medical group, affiliated with 312 bed hospital, located on Florida's Gulf Coast. Population doubling in five years. Advantages of group practice combined with prerogatives of solo practice. Fee for service arrangement with substantial drawing account first year. No investment required. For full details, contact D. M. Schroder, Mease Hospital and Clinic, Dunedin, Florida 33528, telephone (813) 734-6365.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. Ob-Gyn, General Practitioners and Internists. Inquiries regarding practice in this community can be forwarded to Howard G. Armstrong, M.D., Chairman, Physician Procurement Committee, 1330 Miccousukee Road, Tallahassee, Florida 32303. Phone (904) 877-7126.

DEVELOPING MULTISPECIALTY GROUP oriented to the young physician and intelligent growth seeks USA educated Board Certified or Board Eligible specialists. Ideal office adjacent to hospital includes x-ray, lab, ECG, physiotherapy. Negotiated first year salary leading to PA membership, liberal fringe benefits, excellent retirement plan; no investment required. Opportunities exist in this fast growing West Florida coastal town for Internists, and General Practitioners. Contact: H. D. Williams, M.D., President, Williams, Abbey & Sells, M.D's, P.A., Richey Medical Center, P. O. Box 1000, New Port Richey, Florida 33552. (813) 842-8494.

EMERGENCY ROOM PHYSICIAN—FLORIDA CAPITAL CITY: to join other physicians in full E.R. coverage of 511-bed general hospital. 42 hour week, Florida license required. Beautiful location in university town, abundant fishing, water sports and hunting. Excellent schools, choice home sites. Minimum income of $40,000 with opportunity to increase. Contact Dr. George H. Evans, Chairman, Emergency Room Committee, Tallahassee Memorial Hospital, Tallahassee 32303.

INTERNIST OR GENERALIST WANTED to join two doctor practice in internal medicine and geriatrics. Beach area Fort Lauderdale. Florida license. Salary first six months, then partnership. Excellent hospital privileges. A. Joseph Pitone, M.D. and Louis L. Amato, M.D., 2600 N.E. 9th St., Fort Lauderdale, Florida 33304. Phone: (305) 564-7597.

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PHYSICIANS WANTED: Family practitioners (GP), internist-cardiologist, E. R. physicians, psychiatrist. New professional building. No investment required. Contact Claude L. Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

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POSITION WANTED: Physician, many years experience, in good health, available for hospital, private or institution service, southern Florida. Write C-656, P.O. Box 2411, Jacksonville, Florida 32203.

MEDICAL SECRETARY, 15 years experience, desires work at home. Typing, transcribing, medical manuscripts and completing insurance forms. Phone (905) 786-2005, Jacksonville.

PEDIATRICIAN: Age 38, University of Miami trained, Board certified, Florida license, seeking practice opportunities in central or coastal Florida. Contact C-653, P.O. Box 2411, Jacksonville, Florida 32203.

AAFP wants part time or locum tenens. Prefer north Lauderdale or south Pompano Beach area. Available November 1, 1974 to May 1, 1975. Write A. J. Silbiger, M.D., 8653 Tanglewood Trail, Chagrin Falls, Ohio 44022.

UROLOGIST. Board eligible, University trained. Florida license. Age 32, wishes to relocate. Solo, group or association leading to partnership. Write C-655, P.O. Box 2411, Jacksonville, Florida 32203.

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PRACTICE FOR SALE OR PHASE OUT: Unique, long established practice—Internal Medicine and Family Medicine type. Excellent opportunity for physician desiring location in Coral Gables area. Owner leaving state. Write C-651, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL PRACTICE AVAILABLE IMMEDIATELY in Sarasota, Florida. 1,600 sq. ft. Office building three and one half years old with 200 M-E, x-ray, etc. In rapidly growing area. Good coverage. Office for lease or sale. Write: G. P. Chabator, M.D., 2268 Gulf Gate Dr., Sarasota, Florida 33581 or phone (813) 922-9684 or 922-9537.

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HOLLYWOOD, FLORIDA: New medical building in Emerald Hills Medical Square. Excellent location near hospital. Ample parking. Contact: J. Schneider, M.D., 1131 North 35th Ave., Hollywood, Florida 33021. Phone: (305) 961-6774.

VACATION ON SANIBEL: Luxurious air-conditioned condominium on Gulf beach. Two bedrooms, two baths, porch, pool, etc. Minimum rental one week. Contact J. Willson, 119 Dixboro Rd., Ann Arbor, Michigan 48105.

ORLANDO, MERRITT ISLAND, ALTAMONTE SPRINGS, Florida. Four new office buildings now renting. Excellent parking, good locations, competitive rates for customized suites. All locations are suitable for medical suites, with adequate plumbing available. Thirty days occupancy possible. Call (305) 422-4474 for either John Horn or Charles Brooks.

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Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

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- in cystitis, pyelonephritis and pyelitis diagnosed as chronic
- against susceptible strains of the common urinary tract pathogens, usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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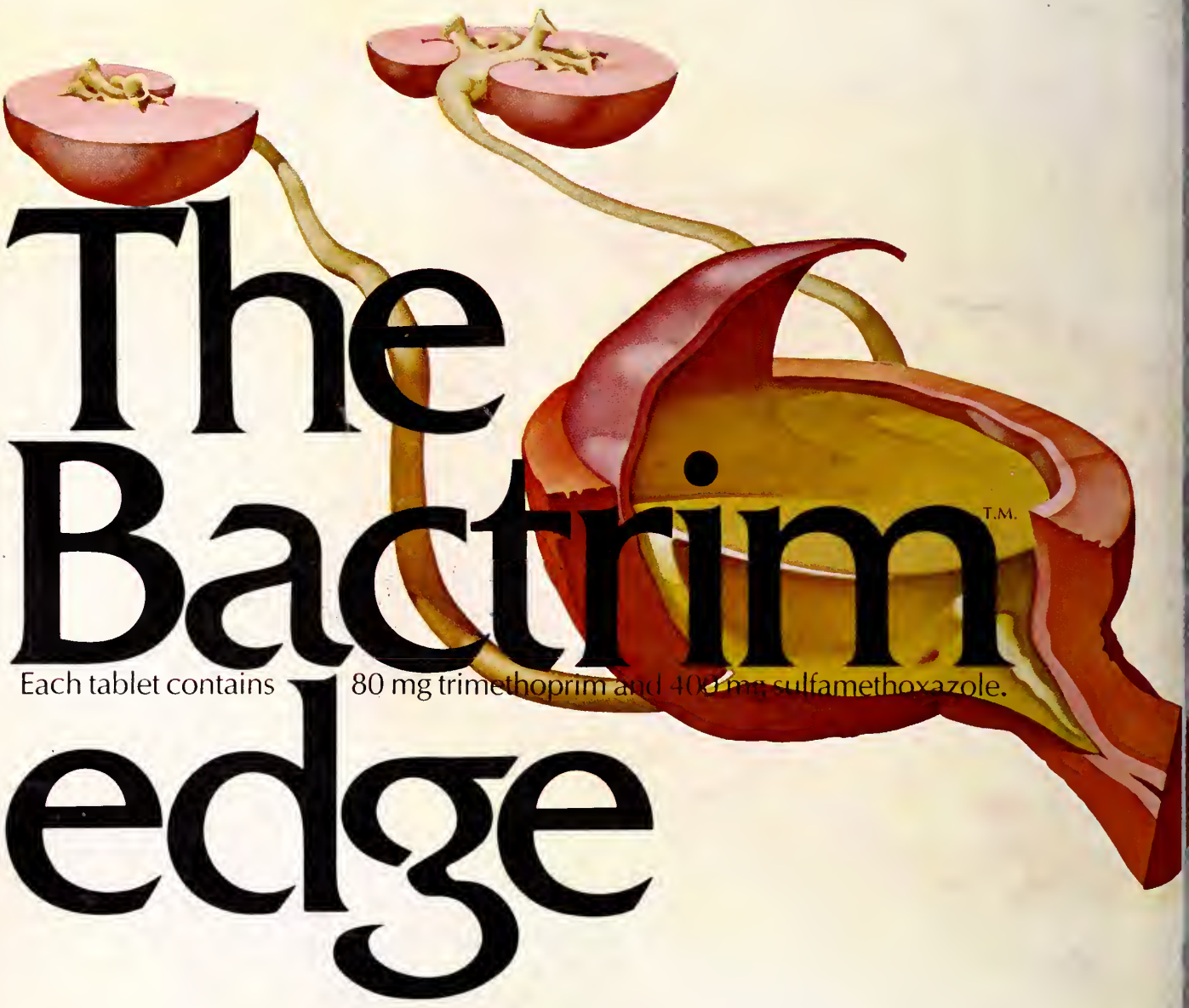

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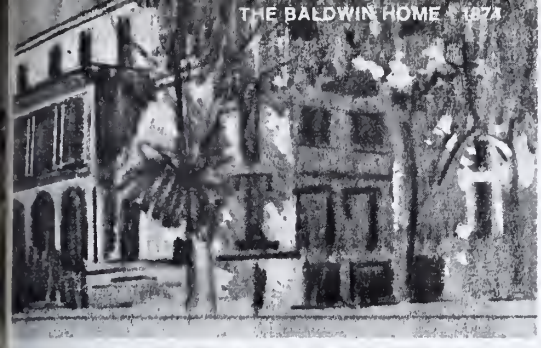

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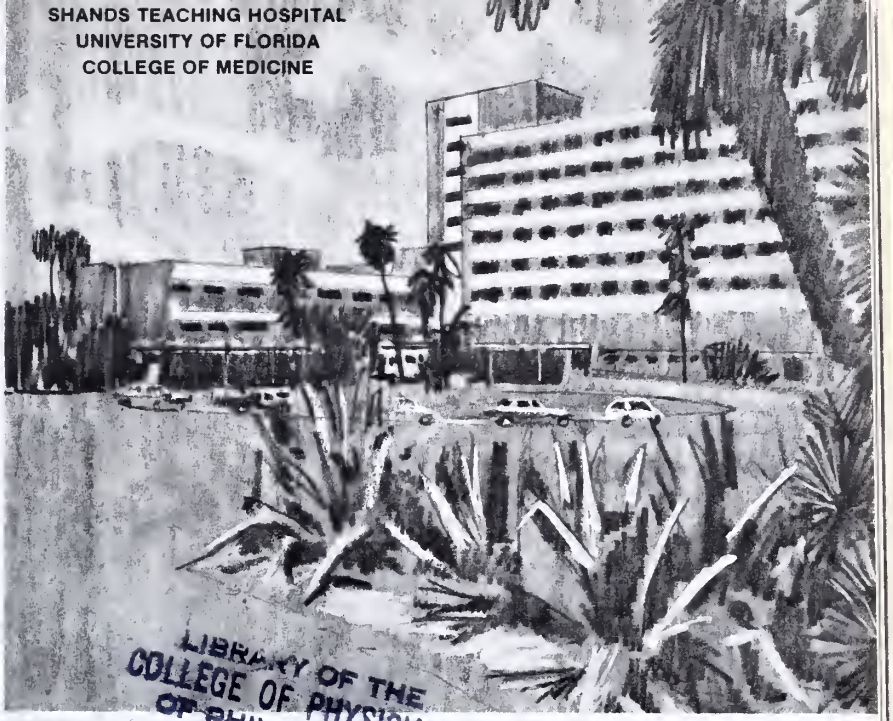

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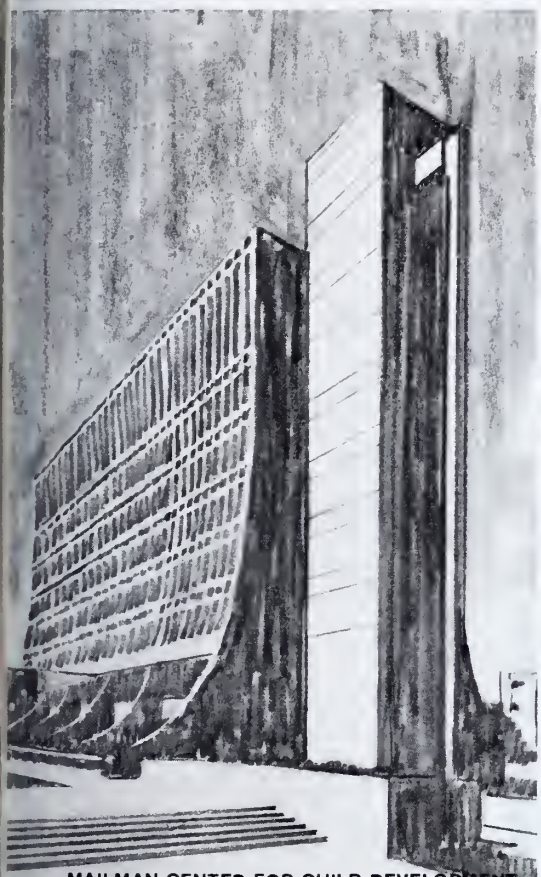

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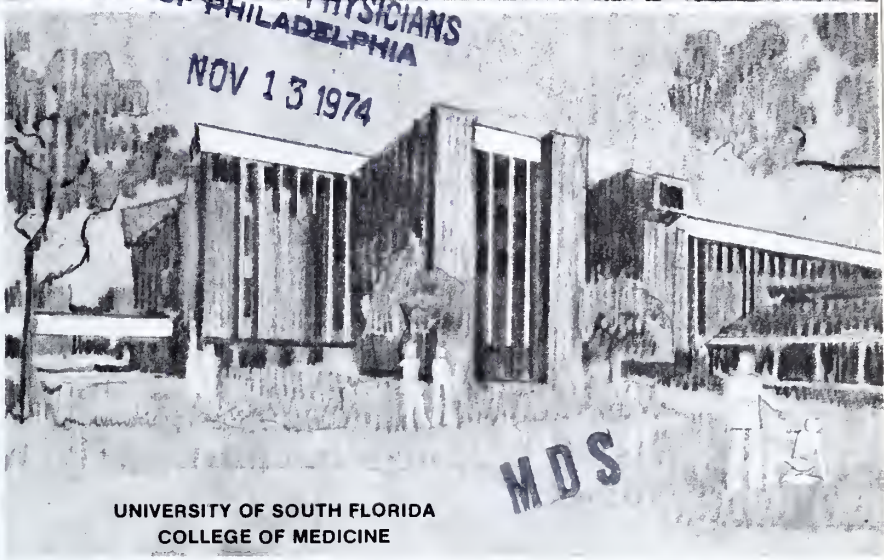

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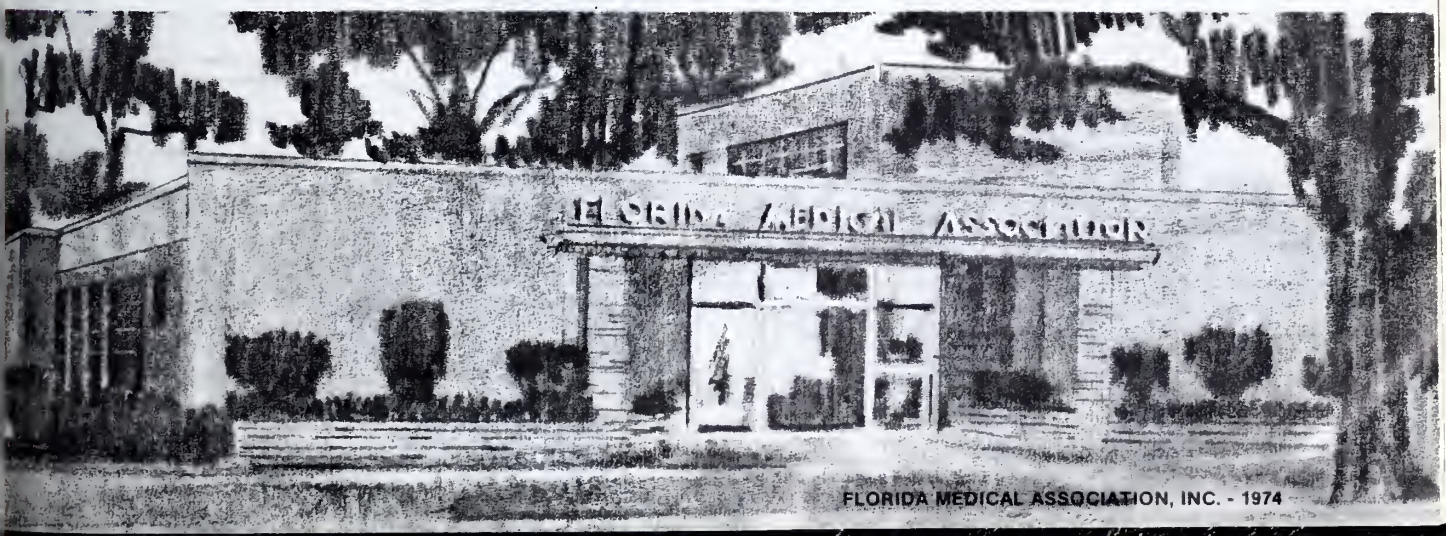

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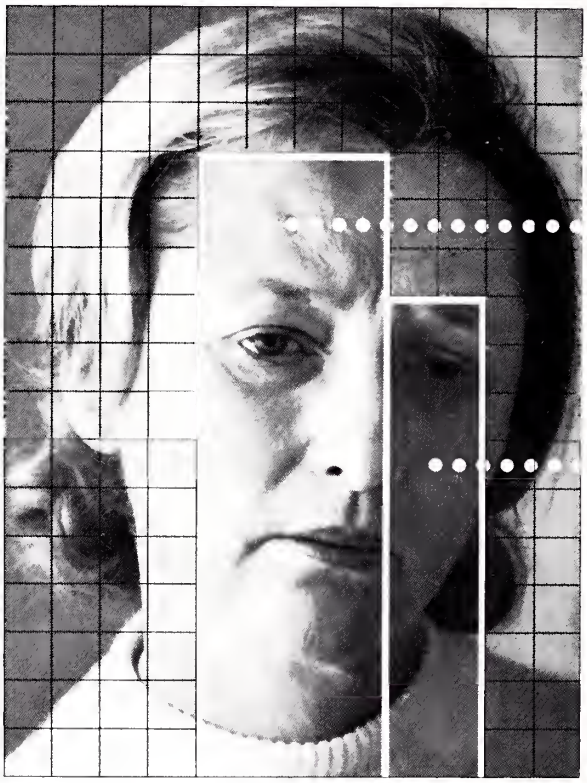

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

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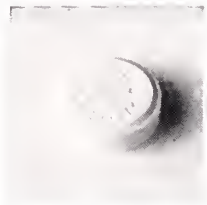
According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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November Cover — (Upper left) The Baldwin Home where first meeting of FMA was held in 1874; (Upper right) Shands Teaching Hospital, University of Florida College of Medicine, Gainesville; (Left) Mailman Center for Child Development, University of Miami School of Medicine, Miami; (Right) University of South Florida College of Medicine, Tampa; (Bottom) Florida Medical Association, Inc. headquarters, 1974.

President's Page

Continuing Medical Education

The continuing medical education program within the Florida Medical Association evolved from the graduate short course sponsored by the Association annually for 25 years, which was discontinued in 1957. At that time Dr. Turner Z. Cason, chairman of the Committee on Medical Postgraduate Course, reported that future courses would be structured in academic environments.

The final short course presented at the University of Florida was to be the "first such postgraduate course presented by the College of Medicine." Dr. Cason stated: "The Committee now envisions its future role as advisory in character and is pleased to cooperate in every way possible to promote medical postgraduate education in this auspicious setting and also to be at the service of other institutions and organizations throughout the state which are active in this field."

The House of Delegates recommended that the Committee be maintained in an advisory capacity and for 14 years its members represented FMA in sponsoring postgraduate courses, offering advice and coordination to prevent duplication of efforts, conducting certain investigations, and publicizing courses and encouraging physicians to take advantage of the training offered. It became the Committee on Continuing Medical Education in 1971.

On May 12, 1973 the House of Delegates approved the Committee's recommendation that 90 hours of continuing medical education within a three year period be required to maintain regular active FMA membership. In October the Board of Governors adopted the Compact for Continuing Medical Education of Physicians as a mechanism to coordinate the programs of all organizations interested in medical education and to revitalize a central registry of these programs.

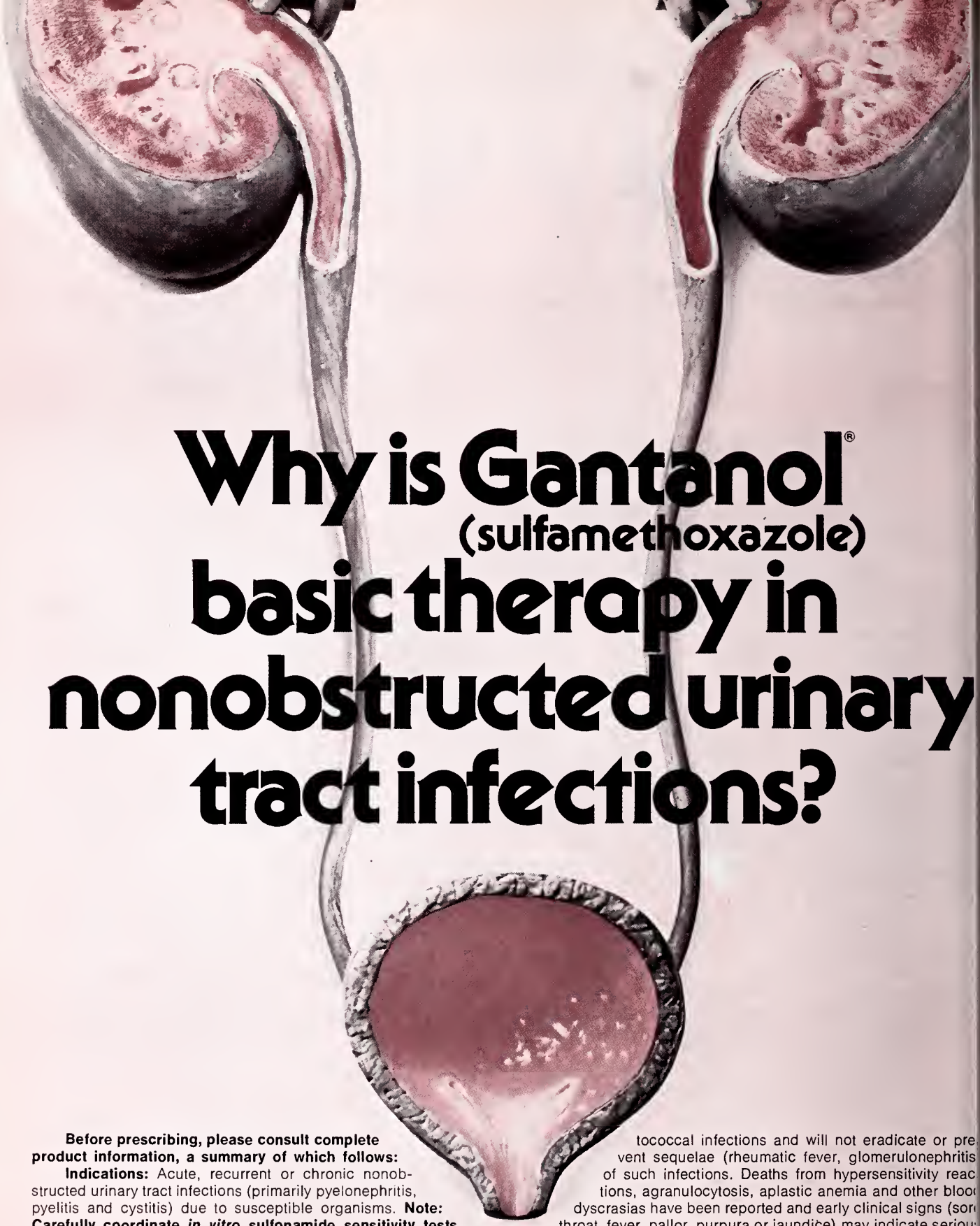
In 1974 each FMA member has received a form for recording hours. The procedure for fulfilling the requirements and the mechanism for filing information and for appealing Committee rulings are also described on the form.

The American Medical Association's Council on Medical Education accorded the FMA Committee on Continuing Medical Education the customary provisional one year approval as an institutional accrediting body of (1) local hospitals which have continuing medical education activities limited to staff and physicians in the local communities; (2) medical organizations not national in scope, that is, county or local societies; (3) local units of voluntary health organizations whose continuing medical education is not under national administration, and (4) other organizations and institutions which sponsor or promote continuing medical education for physicians, essentially local in nature, appropriate to their needs.

Now the AMA has established a data keeping system and the FMA has been selected to participate in a pilot program designed to record physician attendance at medical educational activities. Each county medical society may elect to use this computer printout as the official record for its members.

The 101st Annual FMA Meeting in 1975 offers the Council on Scientific Activities the first opportunity to present a program offering the 20 mandatory hours of approved education at a single meeting. This program is being developed and each of us must participate in the planning if we are to have a scientific program which meets the needs of the Florida physician.

Thad Moseley



Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
- for control of susceptible *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*
- for prompt antibacterial blood and urine levels in from 2 to 3 hours after initial 2-gram adult dose
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- for maximum patient cooperation with easy-to-remember B.I.D. dosage

Basic Therapy

Gantanol®

(sulfamethoxazole)

Tablets/Suspension (0.5 Gm) (0.5 Gm/teasp.)

pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Medical News

Dean Stetson Promoted

Chandler A. Stetson, M.D., of Gainesville, has been appointed Vice President for Health Affairs of the University of Florida.

Dr. Stetson will continue to serve concurrently as dean of the University's College of Medicine, a post he has held since 1972. In the vice presidency he succeeds Edmund F. Ackell, M.D., who resigned.

A native of Boston, Dr. Stetson received his M.D. degree at Harvard Medical School, Class of 1944. Prior to coming to Florida he served for many years as Professor and Chairman of the Department of Pathology, New York University.

Florida Gets Kidney Expert

Robert F. Pitts, M.D., Ph.D., noted kidney physiologist, has joined the faculty of the University of Florida College of Medicine as Research Professor of Medicine and Physiology.

Dr. Pitts comes from Cornell University, where he has been Professor and Chairman of the Department of Physiology for 23 years.

The author of a number of scientific papers as well as a textbook on physiology, Dr. Pitts received his Ph.D. degree from John Hopkins University (1932), and his M.D. degree from New York University College of Medicine six years later.

Nuclear Medicine Chief Appointed

August Miale Jr., M.D., has been appointed Director of the Division of Nuclear Medicine at Jackson Memorial Hospital, Miami. A member of the hospital staff since 1969, he continues as Associate Professor of Radiology at the University of Miami School of Medicine.

Pathologists Open Contest

The Florida Society of Pathologists is accepting entries for the second annual Alfred L. Lewis Jr., M.D., Memorial Research Prize contest.

The $500 prize will be awarded to a pathology resident in Florida who submits a paper representing what is judged the best original research in anatomical or clinical pathology. The award is named for Alfred L. Lewis Jr., M.D., prominent Tallahassee pathologist who was killed in an auto accident two years ago.

Information about the contest may be obtained by contacting: Sanford A. Mullen, M.D., Chairman, Award Selection Committee, Florida Society of Pathologists, P. O. Box 2921, Jacksonville, Fla. 32203.

Organization Changes Names

The American Association of Medical Clinics has changed its name to the American Group Practice Association. In taking the step at the 25th Annual Meeting of the Association, delegates voted to "call us what we are—an association of group practices."

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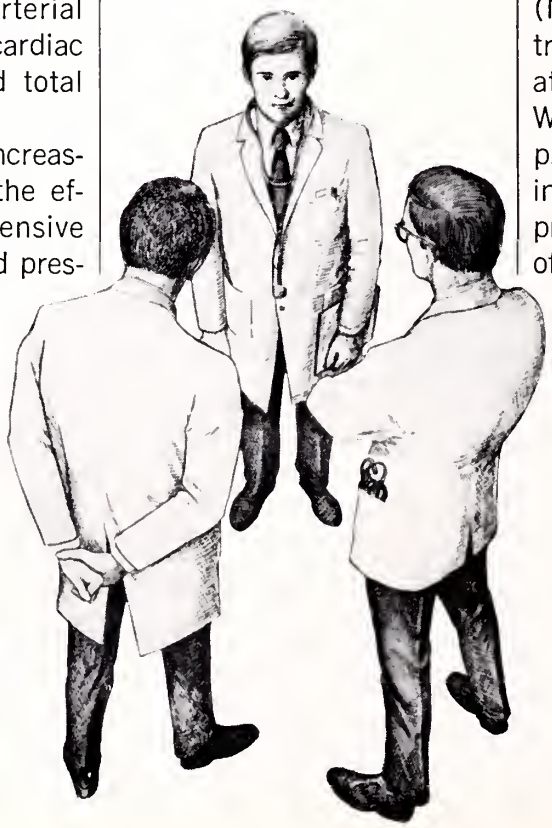
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

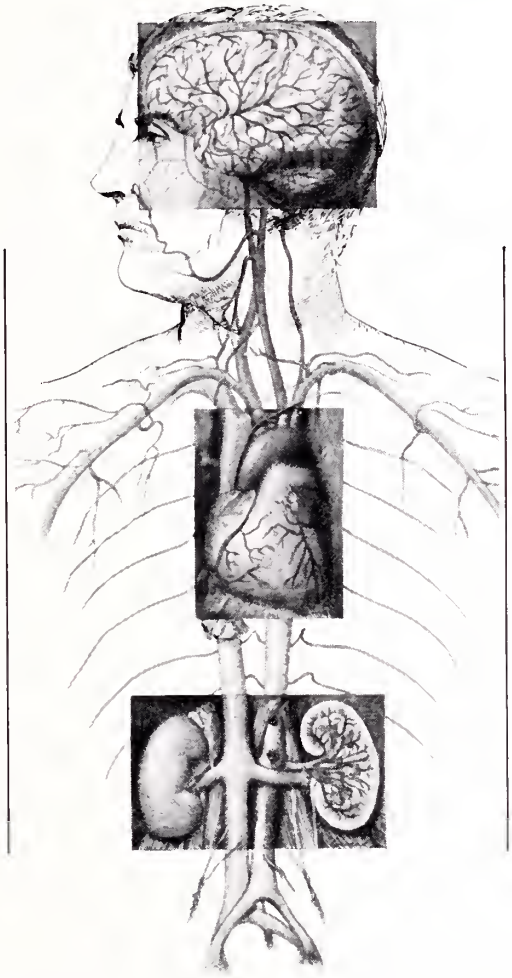
With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive

lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.



Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in 500 mg TABLETS as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET® (METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

"Required Reading" For Your Hypertensive Patients

Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

Entrapped gas...

Silent partner of GI spasm

Painful GI spasm in the presence of entrapped gas causes even more pain and more discomfort. Yet, while spasm is relieved, entrapped gas often goes untreated.

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Sidonna. The therapeutic partnership approach to functional or organic GI disturbances including spastic colon, irritable bowel syndrome, gastroenteritis, gastritis, peptic ulcer and nervous indigestion.

Contraindications: hypersensitivity to barbiturates or belladonna alkaloids; glaucoma, prostatic hypertrophy, pyloric obstruction. **Side Effects:** dry mouth, blurred vision, dysuria, skin rash, constipation or drowsiness. **Dosage:** one or two tablets preferably before meals and at bedtime.

Reed & Carnrick/Kenilworth, N.J. 07033

Sidonna®

Each scored tablet contains: specially activated simethicone 25 mg., hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: may be habit forming.)

A working partnership against the pain of gas and spasm

anavac

anavac

The gentle evacuant that cleans the bowel and diverticuli.

Anavac Tablets contain:
Sodium Lauryl Sulfate...25 Mg.
1,8 Dihydroxyanthraquinone
.....75 Mg.

Action and Uses: Anavac is a gentle evacuant that cleans the bowel and reduces the lytic or digestant action when it comes in contact with the anal skin. The sodium lauryl sulfate seems to gently cleanse the diverticuli by detergent properties. Anavac improves the muscle tone of the flaccid large bowel by gentle peristalic stimulation...accomplished (through the blood stream) by impulses at the Meissner Plexus of the colon. Since the Danthron bypasses most of the small bowel, there is no interference with digestion or fat-soluble vitamin absorption. Anavac is non-cumulative and non-toxic. The sodium lauryl sulfate seems to reduce the overstimulating effects of Danthron.

Administration and Dosage: Adults: one or two tablets after the evening meal with a full glass of water. Children under 12: one-half tablet with fluid after evening meal.

Side Effects: May produce a discoloration of the urine. This is of no clinical significance. May appear in milk of lactating mothers.

Precautions: Frequent or prolonged use may result in dependence on laxatives

Contraindications: Should not be used when nausea, vomiting, abdominal pain or other symptoms of appendicitis are present.

How Supplied: Bottles of 100 and 1000 orange, coated tablets.

For a free clinical supply and literature:
call or write:
Dr. E. Petry, M.D.
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Lenexa, Kansas 66215
(913) 888-8168

DOUGLAS PHARMACAL INDUSTRIES, INC.
DISTRIBUTOR

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not tikely to be ettective or are contraindicated.**

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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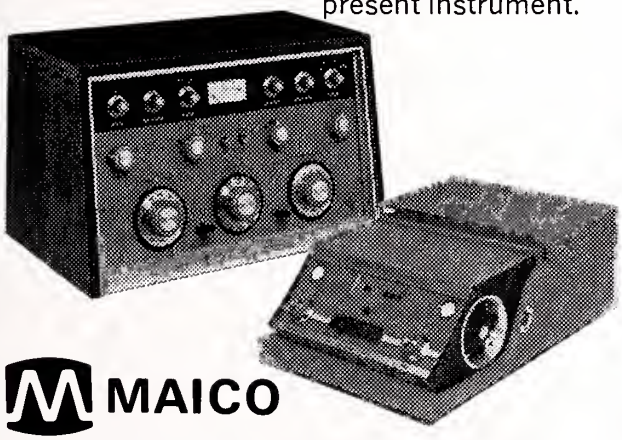

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Chemotherapy of Testicular Cancer

NORMAN L. BLOCK, M.D.

Many physicians feel that the use of chemotherapy is a perfunctory measure to be used just before death. Quite to the contrary however, chemotherapy frequently may extend, sometimes indefinitely, the useful life of a patient with testicular carcinoma.

The rapid change in the nature of chemotherapy can be gathered from a statement in the second edition (1955) of Goodman & Gilman's Textbook of Pharmacology: "It should be stated at the onset that no chemical compound has yet been found which is capable of curing any form of cancer."[1] In the most recent edition (1970) of the same textbook, it is stated " . . . complete remissions for extended periods of time can be consistently produced . . . "[2]

Chemotherapy is useful for testicular cancer of any stage. Where there is no evidence of residual disease following the initial form of therapy, it is used for prophylaxis. When the metastases become apparent it is used for therapeusis. In this discussion, I shall outline some of the factors to consider in a drug program, what drugs are available, their mechanism of action, application of these drugs to testicular cancer and results, and how to manage the problems associated with chemotherapy.

How does one evaluate a patient for chemotherapy? In order to be able to properly evaluate drug responses which may sometimes be unfortunately subtle, a thorough documentation of the parameters of disease stage must be made. This requires a careful examination of each organ system, particularly lungs, liver and skeleton with appropriate biopsy, cytologic, biochemical and radiographic studies. As well as possible, various subjective symptoms must be quantified. In the case of pain, for example, how often does the patient get pain, how often does he take medication for it, what medication does he take and in what dose—all factors which may give early evidence of success or failure of a particular drug regimen. Complicating problems in a particular patient must also be considered. Organ and tissue functions can be deranged by the inroads of cancer. Examples are uremia, liver failure, and pulmonary insufficiency. The aftereffects of treatment by surgical operation, radiotherapy or chemotherapy may cause a variety of disturbances such as anemia, draining abscesses, bone marrow depression, and pneumonitis. Each problem must be carefully analyzed, diagnosed and corrected if possible prior to chemotherapy. Regression of pulmonary shadows or improvement of hepatic status may be due to control of an infectious process and serious errors can result from interpreting these as regressions of cancer because of chemotherapy.

The availability of drugs must next be considered. Since Goodman, Gilman, Dougherty, and Lindskog treated a patient with the first chemotherapeutic—nitrogen mustard—in 1942, a mere 30 years ago, thousands of agents have been tried against experimental tumors, several hundreds

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have been tried in humans, and several dozens remain in clinical use.[1] These agents may be broadly classified as alkylating agents, antimetabolites, natural products and miscellaneous agents.

Alkylating agents act essentially by changing the chemical structure of the DNA helix and thereby disrupting both its structure and its function. Among the alkylating agents the only group useful against testicular tumors has been the nitrogen mustards—all chemically related to the mustard gas of World War I. The ethylenimine derivatives such as thiotepa and the alkylsulfonates such as myleran have not been useful. The nitrogen mustards effective against testicular cancer have been: melphalan, sarcolysin, cytoxan and chlorambucil, primarily the latter two. As do the other alkylating agents, these disrupt the structure and function of DNA. They also inhibit glycolysis, respiration, enzyme activity and protein synthesis.

The second group of agents, the antimetabolites, act essentially by substituting a nonfunctional molecule for a functional one. Methotrexate, for example, mimics the structure of folic acid and by binding folic acid reductase disrupts the vitamin's metabolism. In a similar manner 5-FU substitutes for uracil and 6-MP substitutes for hypoxanthine. 5-FU blocks the methylation of deoxyuridylic acid and disrupts both DNA and RNA synthesis. 6-MP similarly blocks nucleic acid synthesis.

The next group, the so-called natural products, all come from various plants, fungi and bacteria. The two periwinkle alkaloids—vincristine and vinblastine—interfere with mitosis and inhibit RNA synthesis. The tumor antibiotics are produced by various species of the fungus Streptomyces. The ones having significant effects against testicular cancer are: actinomycin-D, adriamycin, daunomycin, bleomycin, and mithramycin. All inhibit nucleic acid function by mechanisms largely unknown.

The last group includes hydroxyurea and nitrofurazone, both of which reportedly have had limited effect on testicular cancer.

Clinical Applications

The various drugs or drug combinations may be divided into those effective against pure seminoma and those useful against the other cell types, pure or in combination with each other.

Seminoma is more successfully treated by x-ray therapy than any other tumor. An overall 5-year survival rate, ranging from 46% to 74% leaves much room for improvement however.

The experience of Chebotareva suggests that sarcolysin is of great value in advanced metastatic seminoma. Remissions occurred in 38 out of 42 patients and 19 patients were alive and fit for work two to six years after treatment was started.[3]

Wu and associates obtained regression of tumor in all of seven patients with seminoma using N-formyl sarcolysin.[4] In two patients, Snyder caused disappearance of metastatic seminoma by the administration of cyclophosphamide.[5] Ankerman and Balfour reported complete regression of a retroperitoneal mass in a patient with seminoma for 4.5 years following the use of nitrogen mustard.[6] Mackenzie reported on the use of chlorambucil in five cases of pure seminoma. All had objective regression of tumor; two had clinical disappearance of tumor and were alive 20 and 21 months after initiation of chemotherapy.[7] Bonadonna reporting on the use of adriamycin in pure seminomas noted that three patients had a response, one had a complete response for 24 months.[8] Steinfeld and colleagues using a combination of melphalan, methotrexate and vincristine for seminoma had responses in three of five patients.[9]

The present regimen employed at Memorial Sloan-Kettering Cancer Center for pure seminoma is chlorambucil, 10 mg daily by mouth for one month. This is repeated at intervals of one to two months depending upon tolerance until evidence of neoplasm disappears and for a period of two years thereafter.[10]

For tumors containing a mixture of seminoma with other cell types, the recommended therapy is chlorambucil, 10 mg daily by mouth for ten days with a single IV injection of actinomycin-D on day five or six of this course. This treatment is continued until all evidence of neoplasm disappears and for two years thereafter.[10]

Next let us consider the treatment of cell types other than seminoma. The various combinations of embryonal cell carcinoma, teratocarcinoma and choriocarcinoma were formerly lumped together in reporting responses to chemotherapy. Recent studies have broken these categories down and show that embryonal cell carcinoma responds better to chemotherapy than either teratocarcinoma or choriocarcinoma.[10]

Many single drug programs have been reported. Mackenzie reported on 22 patients treated

with actinomycin-D; five patients had complete regression of tumor, and five had partial regression.[11] Murphy also reported actinomycin-D to be useful.[12] Samuels reported 21 patients receiving vinblastine. Eleven responses were noted, four of these were complete responses lasting past 42 months.[13]

Mithramycin has been reported by various authors to be effective. Its severe toxicity is mitigated by an alternate day regimen suggested by Kennedy in 1970.[14] Mithramycin appears to have a pronounced specificity for embryonal cell cancer. Of 33 patients with embryonal cell carcinoma treated with mithramycin, 18 had remissions. Of 13 patients with other cell types transient regressions occurred in only four. Kennedy recommended a dose of 50 micrograms/kg/day on alternate days until signs of toxicity appeared.[15] Adriamycin has been used for testicular cancer with ten partial responses in 15 patients.[16]

Wyatt reporting on the use of methotrexate in embryonal cell tumors had ten patients with stage 3 disease; four survived greater than five years. When compared to a mean survival of six months for untreated stage 3 embryonal cell carcinoma the impact of chemotherapy is self-evident.[17] Hydroxyurea has been used in six patients with testicular cancer, two short term objective responses were obtained.[18] Isolated cases of tumor response to intravenous and oral Furacin have also been reported.[19]

In 1960, Li, Whitmore, Golbey and Grabstald began the era of combination chemotherapy with the triple drug regimen for testicular carcinoma. The idea is based on the concept that by decreasing doses of individual drugs and using several drugs concurrently the toxicity to normal cells could be minimized, tumor cells could be attacked at several points in their life cycle, and drug effects could be synergistic.

Using a combination of actinomycin-D, methotrexate and chlorambucil, Li reported 12 responses in 23 cases. It is of note that about half of those responding were choriocarcinomas.[20] Mackenzie reported later experience with the same group. Half had a response, 12% had a complete remission. Eighteen of the nonresponders in this series were failures on other regimens. This fact partially explains the difference between the figures of Li and of Mackenzie.[11]

Ansfield had similar results with the triple therapy of Li. One of his complete responses was a choriocarcinoma, whose response lasted 7.5 years plus.[21] Because of the high response rate but low rates of long-term remission noted with triple therapy, Jacobs added a fourth drug, mithramycin. He noted five regressions including three complete remissions, all three of these were embryonal cell carcinomas.[22]

Several two-drug combinations have been reported. Mackenzie treated 31 patients with actinomycin-D and chlorambucil, 18 responded and in five the cancer was clinically completely eliminated.[11] Jacobs treated 14 patients with nitrogen mustard and actinomycin-D. There were four responses, one complete response — that patient is free of disease at five years. Fifteen patients were treated with nitrogen mustard and methotrexate. There were five responses, two of which were complete.[22] Samuels and Howe using melphalan and vinblastine reported five responses in 11 patients, two of these were complete remissions.[13]

In 1970 Mendelson and Serpick reported on the use of a combination of vincristine, methotrexate, cyclophosphamide and 5-FU. Five cases of embryonal cell carcinoma showed complete remission.[23] The presently recommended therapy at Memorial Sloan-Kettering Cancer Center for tumors other than seminoma is the four-drug regimen of Mendelson and Serpick.

Recently, the Memorial group has been using a combination of actinomycin-D, bleomycin and Velban. In 22 patients who had recurrence after other courses of chemotherapy 18 had objective responses.[10]

Some workers recommend prophylactic chemotherapy for the patient with no evident disease following retroperitoneal lymph node dissection. The rationale for prophylactic chemotherapy is based upon: (1) the known risk of metastases from testis tumors, (2) the not infrequent bypassing of retroperitoneal nodes by metastasizing cells and (3) the greater effectiveness of chemotherapy in the face of minimal-sized metastatic nodules. All of these are well supported by both clinical and laboratory investigations.

Ansfield using actinomycin-D, chlorambucil and methotrexate treated 13 patients prophylactically and obtained these results: five out of seven embryonal cell tumors, one out of one choriocarcinoma, and five out of five teratocarcinomas are living and tumor-free after varying periods of time.[21] These results are significantly better than those with untreated patients and speak in favor of prophylaxis.

Drug toxicity is the great disadvantage of

chemotherapy. The alkylating agents affect the bone marrow and intestinal mucosa. With cyclophosphamide and chlorambucil these effects are minimal, but must be recognized. Alopecia is common with cyclophosphamide but usually reversible. Cyclophosphamide may also cause severe constipation and this problem should be treated prophylactically. All the alkylating agents induce nausea and vomiting by means of central nervous system stimulation. Among the antimetabolites both methotrexate and 5-FU cause severe bone marrow depression and stomatitis, frequently severe. Both cause anorexia, nausea, and diarrhea. Methotrexate also causes alopecia, FUO and a skin rash. Methotrexate must be used with extreme caution in the presence of renal impairment as it is excreted in nonmetabolized form by the kidneys.

Vincristine causes primarily neurotoxicity, manifested by weakness, paresthesias, pain and constipation. Vinblastine depresses the bone marrow predominantly. Actinomycin-D causes bone marrow depression, stomatitis, proctitis and alopecia.[2] Mithramycin's side-effects include liver toxicity and derangement of calcium metabolism. Bleomycin causes FUO and permanent pulmonary fibrosis, occasionally fatal.

The leukopenia seen with bone marrow depression may be treated if severe enough by prophylactic antibiotics and reverse isolation until the white blood count rises above 1000. On the research horizon for drug-induced leukopenia is white cell transfusions although these are not yet generally available. Thrombocytopenias of severe degree are treated by bedrest and platelet transfusions.

Summary

In summary, I have briefly reviewed the application of chemotherapy to testicular cancer. Chlorambucil is the drug of choice for seminoma. It should be combined with actinomycin-D when other elements besides seminoma are found. When the tumor is of nonseminomatous histology, the four-drug combination of 5-FU, cyclophosphamide, methotrexate and vincristine is preferred as the first choice of therapy. Prophylactic chemotherapy in patients with no evidence of tumor after node dissection seems useful at this time. The toxicities of the various chemotherapeutic drugs were briefly discussed. The hazard is nowhere near as great as that of metastatic testicular cancer.

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Erratum

In the September Journal, page 740, under the listing of the specialty group presidents and secretaries, Dr. Gerard F. Carter, of Miami was inadvertently listed as secretary of the Florida Allergy Society. He is the president-elect. Dr. Heinz H. Wittig, Gainesville, is the secretary.

Facial Nerve Paralysis

Case With an Unusual Cause

EDWARD R. MCDONOUGH, M.D.

Abstract: Paralysis of the facial nerve is an entity seen by physicians of many different specialties. When a patient presents with complete peripheral facial nerve paralysis, a systematic work-up is necessary to make a diagnosis, plan treatment, and judge prognosis. Topographic localization of the lesion requires a knowledge of the anatomical course of the nerve as well as the functional components. This case presentation involves an unusual but potentially treatable cause of facial nerve paralysis.

Case Report

This 76-year-old Caucasian male was advised to see an ear doctor by a local osteopath because of "proud flesh" seen in the left ear. Symptoms began 18 months prior to being seen in my office. The initial symptom was left facial weakness with gradual progression to complete paralysis. Twelve months previously he had episodes of dizziness and unsteadiness associated with nausea and vomiting. He had had a hearing loss in both ears for several years, however, the past year this had become much worse in the left ear. He had intermittent pain in the left ear for one year. Nine months previously he was seen by a neurologist and an EEG and skull x-rays were reported to be normal. Three months previously he was seen by a general surgeon for a lump in the left side of the neck. A left superficial parotidectomy was performed. It was noted at that time that the mass was in the tail of the parotid gland and over the lower branches of the facial nerve. The pathology report was squamous cell carcinoma of undetermined origin. Two days postoperative the patient was seen by a EENT physician, asked to evaluate the nasopharynx as a possible origin of the tumor. This examination was reported to be within normal limits.

Physical examination in my office demonstrated total left peripheral facial paralysis (Fig. 1). All other craninal nerves were intact. There was a granular, red, fleshy mass present at the level of the left tympanic membrane, apparently coming from the left middle ear. There was a surgical scar from the previous parotid surgery beneath which several firm nodes were palpable.

Tearing was tested and found to be normal in the left eye. An audiogram revealed a bilateral mixed type of hearing loss which was severe in the left ear. X-rays of the left temporal bone revealed a destructive lesion of the petrous portion. Biopsy of the left middle ear mass proved squamous cell carcinoma.

Following the facial nerve from its origin in the brain stem to the periphery will allow us some insight into signs, symptoms, and tests that would be helpful in our evaluation. Beginning in the inferior pons, the nerve courses to the cerebellopontine angle and then via the internal auditory canal the labyrinthine segment extends to the geniculate ganglion. Lesions in this area produce auditory, vestibular and central symptoms as well as paralysis of the facial nerve.

Figure 1

At the geniculate ganglion the greater superficial petrosal nerve leaves to form the vidian nerve and later supply tearing to the eye. A dry eye generally means the lesion is proximal to the geniculate ganglion. The tympanic portion then crosses the middle ear from anterior to posterior above the oval window. The mastoid portion descends to exit at the stylomastoid foramen. During the descent there are two branches. The stapedial supplies the stapedius muscle. This muscle helps control loudness. If this is involved, the patient complains of sensitivity to loud sounds—phonophobia. The second branch is the chorda tympani. Injury to this nerve causes loss of taste for the anterior two thirds of the tongue on the involved side. After leaving the skull, the nerve rapidly branches so that the distal lesions do not give total paralysis.

This case is one of squamous cell carcinoma of the middle ear with initial symptoms dating 18 months prior to diagnosis. Symptoms at that time involved facial nerve weakness followed by labyrinthine and cochlear symptoms and finally those of metastatic disease. Squamous cell carcinoma of the middle ear is a rare but potentially treatable entity. We must remember that all facial paralysis does not fall into the category of "Bell's Palsy." These patients need a complete evaluation in order to avoid errors in diagnosis and management.

▶ Dr. McDonough, 2800 South Seacrest Boulevard, Boynton Beach 33435.

Appreciation is extended to G. Boyd, M.D., and F. Kucera, M.D., whose contributions made this paper possible.

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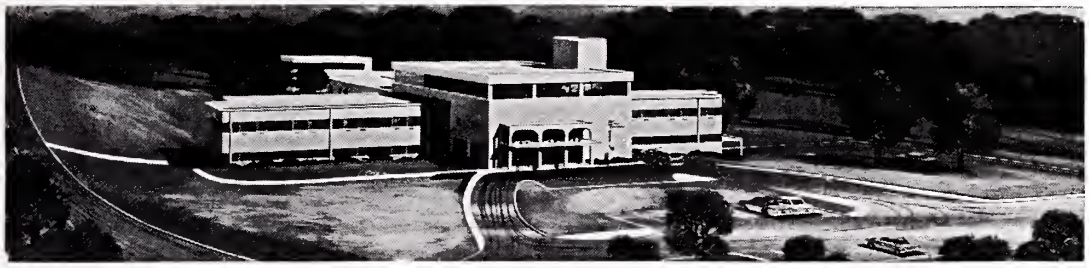

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Deaths

Bunim, Louis A., Miami Beach; born 1899; New York University, 1923; member AMA; died May 3, 1974.

Drazin, Morris L., Orlando; born 1897; New York University, 1927; member AMA; died August 16, 1974.

Freidus, Elias, Miami Beach; born 1896; University of Maryland, 1922; member AMA; died—date unknown.

Heck, Maurice E., born 1886; University of Buffalo, 1911; member AMA; died July 4, 1974.

Helms, John S. Jr., Apopka; born 1903; Tulane University, 1929; member AMA; died August 14, 1974.

Shaver, Edward F., Tampa; born 1898; Tulane University, 1924; member AMA; died July 13, 1974.

Thomas, Edwin C., Coral Gables; born 1891; University of Oklahoma, 1914; member AMA; died June 21, 1974.

Tight, Alvin J., Fort Lauderdale; born 1910; St. Louis Medical School, 1936; member AMA; died January 1974.

Wells, Leila H., Jacksonville; born 1916; George Washington University, 1941; member AMA; died July 22, 1974.

Notice to Subscribers

Increasing postage and publication costs have forced *The Journal* to raise subscription rates, effective January 1, 1975. On that date, single copies will go from 70¢ to $1.00. One-year subscriptions will increase from $7.00 to $10.00. Two- and three-year subscriptions will be available at $18.00 and $26.00. All subscriptions and renewals entered on and after January 1 will be billed at the new rate.

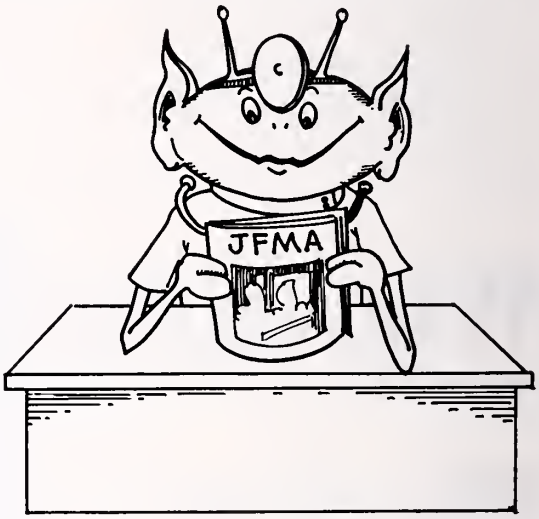
Letters

Dear Earthdocs:

Greetings! I hope your editor and finance manager see fit to print this communication. I understand that J.F.M.A. has an austerity program right now. I am doing my bit by making this letter brief. You have my permission to use small type.

I understand your difficulty. We are having the same thing on Mars right now. Earnings are at an all-time high but expenses are climbing at a faster rate. Perhaps we will have to use the same computers to retape information in physician brains but more on that when we solve our problem. I will be interested in how you solve yours.

I am already looking forward to the meeting next April of the Flatland Medical Association. In case you have forgotten what I look like, I am sending a picture of myself reading a very thin J.F.M.A.



Best wishes,
Martiandoc

Drug Information and Pharmacy Resource Center

To the Editor: The Drug Information and Pharmacy Resource Center at the College of Pharmacy, University of Florida has received approval of a one year contract with Florida Regional Medical Program, Inc. to improve and expand services offered by the Center. The major impact of the contract will be the support of an incoming WATS telephone line, thus allowing toll free telephone access by all state physicians, pharmacists and other health professionals. The Drug Information and Pharmacy Resource Center can now be reached toll-free by dialing *1-800-342-1106*. Those in the Gainesville area may continue to reach the Center using the 392-3576 telephone number Monday through Friday from 9 a.m. to 5 p.m.

M. Peter Pevonka
Director, Drug Information and Pharmacy Resource Center

What does man have in common with Samson?

Neither man nor the gorilla can synthesize vitamin C. Interestingly, the slow loris, a primate much further down the evolutionary scale, can convert L-1,4-gulonolactone to ascorbic acid in its liver and presumably does not require an exogenous source of ascorbic acid.

Because man can neither synthesize vitamin C nor store most of the water soluble vitamins, these nutrients must be replenished continuously in order to maintain normal tissue levels.

Generally, this is accomplished in his daily diet. But under conditions of illness, stress, in convalescence or following surgery, vitamin stores may be depleted or metabolic demands increased.

In such cases, Surbex-T may be indicated. Surbex-T restores the water-soluble vitamins with each tablet providing 500 mg. of vitamin C plus high potency B-complex.

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SURBEX-T® 500 mg. of Vitamin C with High Potency B-Complex

Restores what the body cannot effectively store

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When diarrhea wrings the wedding belle...

It's all very well to counsel patience in diarrhea patients. There are times when relief of symptoms can't come too soon.

X-ray studies[1] in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

1. *Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.*

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . 2.5 mg.
(Warning: May be habit-forming)
atropine sulfate . . . . . 0.025 mg.

Saves the Day

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: ***Tablets,*** 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. ***Liquid,*** 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Each Spansule® capsule contains 8 mg. Teldrin®
(brand of chlorpheniramine maleate);
50 mg. phenylpropanolamine hydrochloride;
2.5 mg. isopropamide, as the iodide.

Fast relief of upper respiratory congestion and hypersecretion* with convenient b.i.d. dosage.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Indications**
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Possibly effective: For relief of upper respiratory tract congestion and hypersecretion associated with vasomotor rhinitis and allergic rhinitis, and for prolonged relief.

Lacking in substantial evidence of effectiveness: For relief of nasal congestion and hypersecretion associated with the common cold and sinusitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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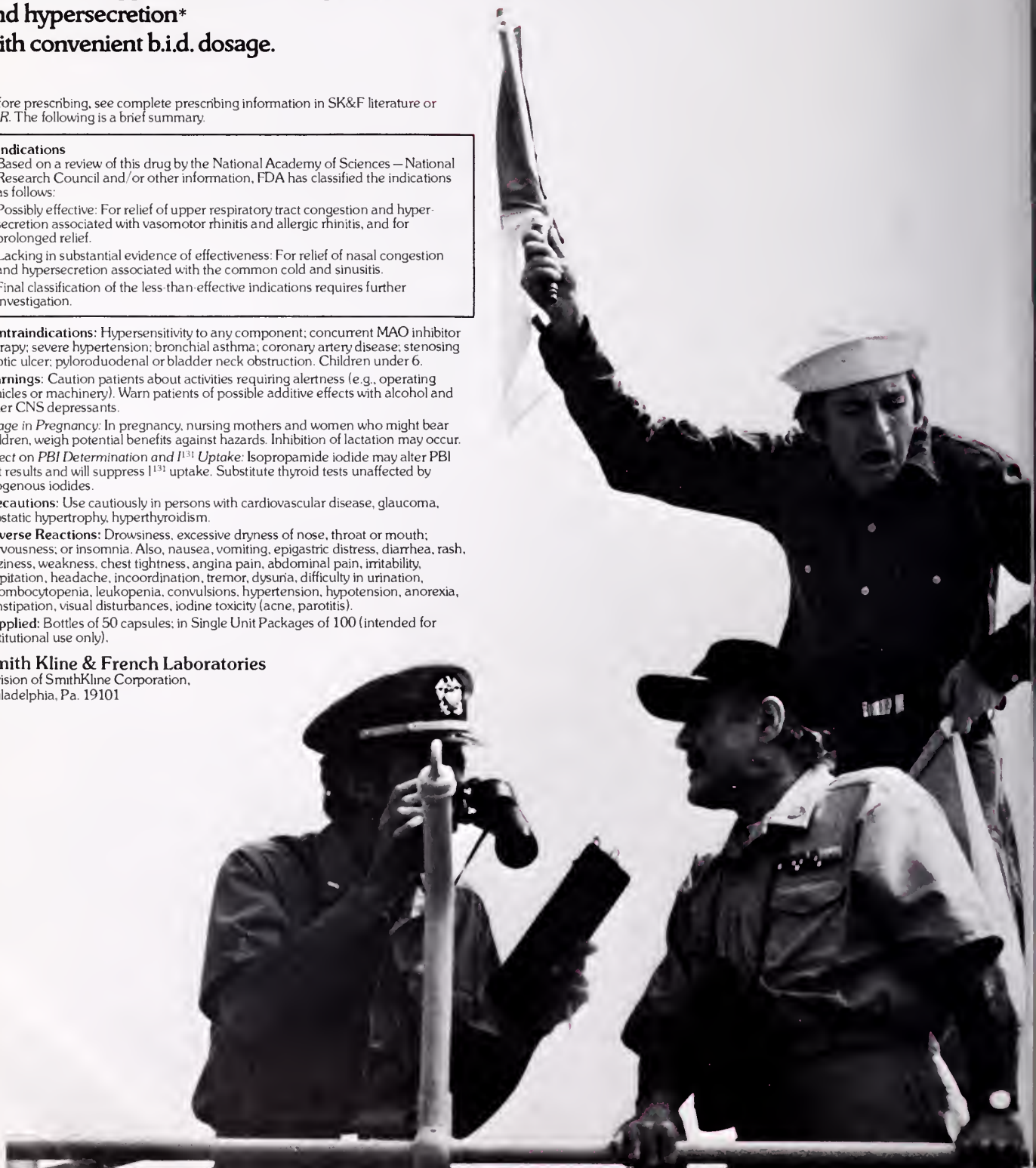

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*Based on surveys of average daily prescription costs.

Butisol SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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MEDLINE

Do You Know?

Shirley L. Maccabee, M.L.S. and Susan E. McCarthy, M.Ln

Do you have an interesting case on which you would like to compare notes? Do you need to catch up on new methods of diagnosis or therapy? Do you want to report your clinical observations and check if anyone else has noted the same thing? Are you undertaking a research project or a book? Do you want to find out what a colleague has written recently? Do you know that MEDLINE can provide you with a list of references on any medical topic, quickly, thoroughly and inexpensively?

What is MEDLINE?

MEDLINE is the computerized medical literature indexing and retrieval system of the National Library of Medicine. It is an "on-line," "interactive" system, which means that a searcher, using a typewriter-like terminal connected by telephone to the computer at the National Library of Medicine, can type in your subject request and receive a printed bibliography of journal articles in a matter of minutes.

At the present time the MEDLINE system contains approximately 500,000 citations from 2,400 of the world's biomedical journals. These are the same references that are contained in the monthly volumes of Index Medicus and in their annual cumulations. But with MEDLINE you can go through more than three years' worth of Index Medicus with only the effort it takes to contact a MEDLINE center and describe the subject you want searched.

What can MEDLINE do that cannot be done by hand?

MEDLINE has three outstanding advantages over searching Index Medicus by hand. First, to cover the three-plus year period currently available on MEDLINE, one would have to look in three separate cumulations, plus several monthly issues of Index Medicus. Second, each article in the system is assigned an average of 12 index terms, but the article generally appears under only three of those headings in the printed IM. With MEDLINE the article can be retrived under all 12 headings, so your search can be much more thorough. The third is MEDLINE's most significant advantage: it allows you to pinpoint your subject by searching for a combination of two or more terms. The following examples help illustrate these features:

1. The subject request was "seizures following heart valve replacement." To do a thorough job by hand you would have to look under "heart valve prosthesis," five separate "epilepsy" headings, and "convulsions." You would have to scan 4,486 titles under seven subjects in up to 18 separate volumes. In just three minutes MEDLINE went through 8,092 titles to pick out the two that matched the request!

2. One researcher was interested in "noise effects on the cardiovascular system." In 16 minutes MEDLINE located and printed 80 citations that resulted from matching 11 cardiovascular terms, assigned to 32,411 documents with "noise" or "sound." A comparable hand search would require scanning well over 12,000 titles.

What else can MEDLINE do?

MEDLINE can locate and print references to all articles by any given author; it can restrict your search to review articles only, to English or other languages, or to a one-year time period. You can specify sex, age group or research with human or animal subjects. There are many additional ways that your librarian or MEDLINE analyst can make the bibliography even more custom-tailored.

Can MEDLINE be used often to keep up-to-date on a subject?

Mrs. Maccabee and Ms. McCarthy are Reference Librarians at Calder Memorial Library, University of Miami School of Medicine, Miami.

A special file called SDILINE (Selective Dissemination of Information On-Line) contains the most current month of Index Medicus, several weeks before the printed issue is available. You can arrange for a MEDLINE center to search your subject in SDILINE automatically each month and send you the bibliography. In this way you are alerted to new articles with no extra effort, and much earlier than if you checked IM regularly by hand.

Who can use MEDLINE?

MEDLINE is available to you as a physician, medical researcher or health professional, wherever you are located. It is especially valuable to rural physicians who may not have frequent access to a large medical library. Indeed, MEDLINE centers are obligated to extend the service beyond their regular clientele to members of the biomedical community at large. In 1973, more than 300 searches were performed at Calder Library for health professionals not associated with the University of Miami. A recent questionnaire sent by Calder Library to its MEDLINE users indicated that these "outside" users were generally well satisfied with the assistance MEDLINE had given them in their clinical and research work, and that it was well worth the cost. Charges for the service are currently under review, but they will not exceed $7.50 for 30 minutes of search time. SDILINE charges are substantially lower.

What does the MEDLINE printout consist of?

MEDLINE will first tell you how many citations it found that satisfy your search request. The librarian will either print out the citations for you immediately on the terminal, or they will be mailed directly to you from the computer center. In either case the information you receive will consist of: (1) author(s); (2) title or English translation of foreign title; and (3) source (journal title, volume number, paging, date). This is all the information you will need to procure the articles you want from a medical library.

How can the articles cited by MEDLINE be obtained?

The library at the MEDLINE center where your search is run will have many of the journals you need. You can read them there in the building or photocopy them on a coin-operated copying machine. If you have borrowing privileges there the library will make every effort to obtain for you through interlibrary loan photocopies of any articles they do not have. If you have requested your search by phone or mail, the librarian can advise you how to request interlibrary loan photocopies, usually free of charge, through your nearest hospital or health center library. Thus a physician located at a distance from a medical library has access to any article cited by MEDLINE.

Where is MEDLINE?

The Florida medical profession is now served by four MEDLINE centers. These are located at the Calder Memorial Library of the University of Miami School of Medicine in Miami (305) 547-6648; J. Hillis Miller Health Center Library of the University of Florida College of Medicine at Gainesville (904) 392-3261; Medical Center Library of the University of South Florida College of Medicine at Tampa (813) 974-2675; and James L. Borland Medical Library of the Jacksonville Hospitals Education Program (904) 353-8574. The procedures described in this article refer to the service as provided at Calder Library in Miami, but the policies at all four locations are similar.

How can one arrange to use MEDLINE?

To have a MEDLINE search run you need only visit, telephone or write the center nearest you. If you come personally to the library, the analyst will go over your request with you and decide on the most appropriate subject headings to use. Requests are usually processed the same day as they are received, and if you visit the center in person the librarian will try to run your search immediately while you watch.

Why not let MEDLINE help you next time?

Computers have been used to aid in the compiling of bibliographies for some time, and individualized literature searching by computer is not new to scientists. Only in the past two and one-half years, however, has a speedy, convenient literature retrieval system been available to busy physicians who do not ordinarily have the time to come to the library and go through indexes. It is hoped that many more Florida clinicians and researchers, especially those distant from the large libraries, will take advantage of this invaluable tool for accessing medical literature.

Health Care in Colombia

Betsy Purdum, Richard Gordon and David N. Michelson

During the summer of 1973, two medical students and an anthropology student went to Colombia, South America, to observe the public health care system and to establish contacts for the purpose of possible future development of an exchange program between Colombian and U. S. medical students. The project was sponsored by the Department of Epidemiology and Public Health of the University of Miami School of Medicine, Miami.

We spent six weeks in the Department of Antioquia,* a predominately temperate, mountainous region in the western cordillera of the Andes mountains, famous for its orchids, Aguardiente (a liquor distilled from sugar cane), and its high fertility rate.[1] Our program included visiting hospitals of various levels of sophistication, from the 700-bed university hospital, San Vicente de Paul, in the capital city of Medellin to the tiny "puesto de Salud" (health station) in the isolated town of Alejandria. During these visits we observed medical facilities and practices and informally interviewed medical personnel.

In the mid-1960's the Colombian government began to recognize the need to accelerate its public health program. This occurred partially as a result of statistics gathered in the early 60's which showed Colombia to have a lower ratio of hospital beds to people (2.7 per 1,000) than either the Soviet Union (9.4 per 1,000), United States (8.9 per 1,000), or Latin America as a whole (3.4 per 1,000). Antioquia represented one of the most highly developed health systems in Colombia as early as 1964. There were 3.2 beds per 1,000 inhabitants, 114 hospitals and 121 health stations which served ambulatory patients.[2]

Colombian physicians receive training which essentially parallels that of their U. S. counterparts. After high school the student directly enters medical school for a period of six years. Since there are little or no funds available for scholarships or loans, money is a prerequisite for attendance. In any case, those of the poorer classes, who would most benefit from such aid, rarely finish high school. Although the poor are excluded, there are far more women in medical school (30%-40% in the most recent class at the University of Antioquia) than in the U. S.

The first two years of medical school include humanities and premed sciences. All students are required to continue their study of English, begun in the high schools, since many of the texts used later are in English. However, the students we met did not speak very much English since their classes were structured to produce reading rather than speaking ability. During the third year the study of the basic medical sciences begins. The courses are roughly equivalent to those studied in the U. S. although there is a shift in emphasis corresponding to the particular health problems of their country. Included in the curriculum are anatomy, biochemistry, physiology, histology, microbiology, parasitology, pathology, and pharmacology. Parasitology is particularly important and is studied for a year. Pathophysiology and behavioral sciences are not part of their studies.

The last two years of medical school are clinical and, like those in the U. S., the Colombian students rotate through the various services. After graduation, internships begin, and although they last for the same amount of time as in the U. S. the doctors spend varying lengths of time at different hospitals. At present, participating hospitals (outside Medellin but within the Department of Antioquia) include only those in Rio Negro and Apartado, but plans exist to expand the program to other areas. Such a system provides the doctor with first hand knowledge of the health problems of widely different climatic regions (Rio Negro—mountainous, Apartado—coastal jungle).

When internship is completed, any doctor who wants to practice medicine within the country is obligated to work for a year in a town with fewer than 20,000 inhabitants (the rural year). The doctors with whom we spoke felt that this was a particularly valuable experience since each doctor in the rural year was the only medical resource in his area. Consequently he learned to deal very quickly and effectively with everything from mule kicks to heart disease. We spent several days with a doctor in her rural year and were very impressed with her thoroughness and ingenuity. She

Mr. Gordon and Mr. Michelson are third year medical students at the University of Miami School of Medicine, Miami and Ms. Purdum is a graduate student in anthropology at Florida State University, Tallahassee.

*Antioquia is one of 22 departments or states in the Republic of Colombia.

saw patient after patient for seven hours without a break. If she was unable to diagnose or treat their problems, she would arrange for them to go to the regional hospital in Rio Negro where more complete diagnostic testing such as x-rays and lab work were available. At one point the lights went out, including the one over the microscope. (This instrument is in constant use since all patients have microscopic examination of stool for parasites.) The doctor simply moved the microscope to the doorway, used the light from the sun, and continued the examination.

Like doctors, dentists (who receive the same training as doctors for the first four years of school) are required to practice for a year in the country. All public hospitals, except health stations which have neither a full-time doctor or a dentist, are staffed with at least one dentist. The majority of these dental offices are equipped with modern chairs, pneumatic drills, and x-ray facilities. Upon entering school all children are given a dental exam for which they pay in accordance with their families' income. Yet perhaps as many as 40% of the children do not attend school and consequently do not receive dental care. The fee system works by having the "rich" pay a little more to cover the cost of the materials for the poor. We looked at one dentist's fee book, and it seemed very reasonable. The materials for one filling cost 10 pesos (50 cents), so one child pays 15 while another pays 5 pesos. It looked so reasonable that we thought maybe we would have the dentist clean our teeth. "Well, for you" he said, "300 pesos (15 dollars)!"

Although doctors emphasized the importance of their rural year, few remain in the country since salaries and opportunities for such things as education and recreation are greater in the city. Salaries in the cities differ significantly from those of U. S. doctors even when the difference in the cost of living is taken into account. This discrepancy has been the cause of much discontent among young doctors, some of whom speak of such drastic measures as striking in order to rectify the situation. For this same reason, many doctors express a strong desire to come to the U. S. In Colombia interns receive $300 a year, likewise doctors in their rural year receive $300 plus payments from "private patients." This amount varies greatly from town to town since some areas have many rich people while others have none. General practitioners in hospitals are paid approximately $500 a month. It appeared that the incomes of specialists engaged in private practices are much higher, but we were unable to gather any specific data.

The environment in which the Colombian doctor practices and the problems which he or she has to face differ substantially from those of the U.S. Many areas are accessible only by winding gravel roads through the mountains. The public health system was designed taking factors of population and accessibility into account. Thus, the smallest hospitals are generally located in relatively isolated areas with small populations while the larger hospitals, providing services of specialists and labs, are found in larger, more centrally located and accessible towns.

Following this model the Department of Antioquia has been divided into seven areas. Each section is to contain a regional hospital. At present only two are fully functioning—at Rio Negro and Apartado, with 50-60 beds, x-rays, labs, and four specialists, internist, pediatrician, obstetrician, and surgeon. The staff of the regional hospital further includes general practitioners, interns, nurses, and nurses aides. Detailed plans also exist for the development of various local hospitals with 15-30 beds, general practitioners, nurses and nurses aides plus numerous rural hospitals with 4-6 beds and staffed by doctors in their rural year.

A large number of the people who seek medical care suffer from problems caused by their living conditions. We were frequently told that 70% of the people are malnourished and that at any time 50% have amebiosis. In some towns nearly all the children have stiff, streaky blond hair because of protein deficiency and bellies distended from muscle wasting and parasitosis. These children are known as "sugar babies" because they are given "agua panela" (sugar cane water) to drink instead of milk. Diseases which no longer seriously threaten those of the U. S. such as polio, measles, TB and malaria are still killers in Colombia where immunization programs are sorely lacking.

We did not observe any evidence of the practice of psychiatry within the public health system except one afternoon when we met two volunteers who brought children from the children's psychiatric ward outside to meet us. Within Antioquia (population 17,500,000[3]) there are only eight beds available for such children. Although it was emphasized that the children's problems were mental, many appeared to be quite ill physically.

A number of these children had been abandoned at the hospital's front door and remained for long periods of time because they had no place else to go. We also heard a doctor, without any malice, refer to certain patients as "crazy" without further qualification or suggestion of treatment. It became obvious to us that a country in which the majority of the people are malnourished simply cannot afford the luxury of psychiatry.

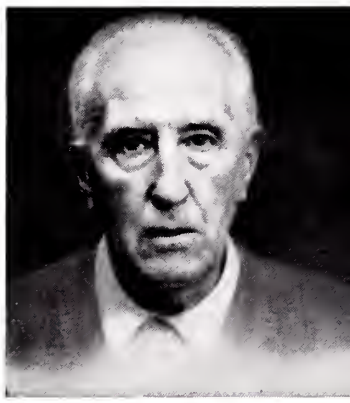
Throughout our trip, the Colombian people were extremely hospitable. Both students and university officials were very receptive to the idea of student exchange. Students from both countries would greatly benefit from such a program. The Colombians would have an opportunity to participate in a system with greater amounts of equipment and research possibilities while those from the U. S. would have the chance to develop skills of recognizing and treating illness not by relying on complex laboratory procedures but by learning to improvise and to use the tools of their own senses.

Finally, adaptation for an American student in Colombia requires a willingness to confront and accept the challenge of a foreign environment. We arrived speaking little Spanish but learned quickly from those around us who recognized our eagerness to communicate. We ate well in the city but had to get along on less bountiful and familiar fare as we toured the smaller towns. We quickly made acquaintance with amebiosis but cured ourselves early, largely due to the company we kept. Since we were traveling our sleeping accommodations ranged from hotels in the city to more improvised hospital beds or apartment floors in rural towns depending upon available facilities at the moment. Accommodations in the city cost a bit less than comparable facilities in the U.S. Outside the city, however, there are no accommodations without a personal host. It was apparent that an effective program for students would require mutual hosting by and for those participating as well as supplementary funding to cover the difference in living costs between the two countries.

References

1. Vallejo, Cesar: La Situation Social en Colombia. Bogota, Centro de Investigacion y Accion Social, 19/1, p. 88.
2. Ibid., p. 90.
3. Ibid.

▶ Mr. Gordon, 517 Madeira Avenue, Coral Gables 33134.



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Editorial

Actions on the Professional Liability Front

Physicians in New York will be watching with hope and concern as that state sets into motion a system of medical malpractice mediation. Becoming law on September 1, 1974, this pretrial disposition of medical malpractice suits was proposed to alleviate some of the problems now vexing patients, physicians, attorneys and courts. One stated advantage is that of expediting disposal of professional liability cases so as to avoid the long delay which now prevails with cases scheduled four and five years hence and settlements consequently increased by spiraling inflation. Also by discouraging unwarranted claims, this is supposed to diminish the need for trial by jury for the patient with a meritorious claim providing a dignified method of just compensation without rancor. Ultimately, it is hoped that this could be expanded to some form of binding arbitration.

Under the newly enacted law, appellate divisions of the State Supreme Court, to facilitate hearings, establish three-member panels consisting of a justice of the supreme court, a physician and an attorney-at-law. Prior to the date for the hearing, the panel reviews all pleadings, bills of particular as well as medical and hospital reports. The hearing that follows, is informal and without a stenographic record but comprehensive and with a view to achieving settlement. After listening to counsel for the litigants and the defense, the panel goes into executive session, following which recommendations are made to both attorneys as to whether the case has merit or is unjustified. No statement or expression of opinion made in the course of the hearing can be used as evidence in any subsequent trial nor can panel members participate in such a proceeding. If any disposition is reached, an appropriate order is entered. If a further hearing is deemed advisable, the presiding justice may so direct. If the case is not settled, it is remanded to its regular place on the court calendar.

In operation since September 1971, a solitary New York County program has produced experiences suggesting a salutary effect. There appears to have been a considerable reduction in the number of malpractice cases awaiting trial. Experiences gained by physicians from closer association with attorneys and judges in an informal but disciplined atmosphere have been beneficial, with the two professions brought together in an atmosphere of mutual understanding, engendering wholehearted response from all. Whether, however, the availability of impartial medical specialists, in cooperation with the legal profession providing both sides with an impartial opinion, will do much to dissuade the trial lawyer on a contingency basis from accepting a client with a real or imaginary complaint, remains to be seen.

In New York, where the medical profession saw its professional liability insurance program cancelled last year and premiums increased by 100% this year to attract a new carrier, it is understandable why the new law has been overwhelmingly accepted with enthusiastic cooperation. Other states will undoubtedly be interested in direct proportion to the rise of their own professional liability premiums and the success of this program.

Recently enacted in Georgia is a law in which consent by the patient given in writing is conclusively presumed to be a valid consent and hopefully, will aid the physician in combating unscrupulous allegations by patients that they were not so informed. Alaska, this year, passed a new "res ipsa loguitur" law which stated "there shall be no presumption or inference of negligence" but the plaintiff has the burden of proving by a preponderance of evidence the negligence, since injury alone does not prove negligence.

At the present, the physician's best defense against malpractice suits remains the taking of a careful, detailed history, staying within the limits of his own abilities, keeping up with new advances in his field, requesting consultation when in doubt and maintaining a good relationship with the patient.

C. M. C.

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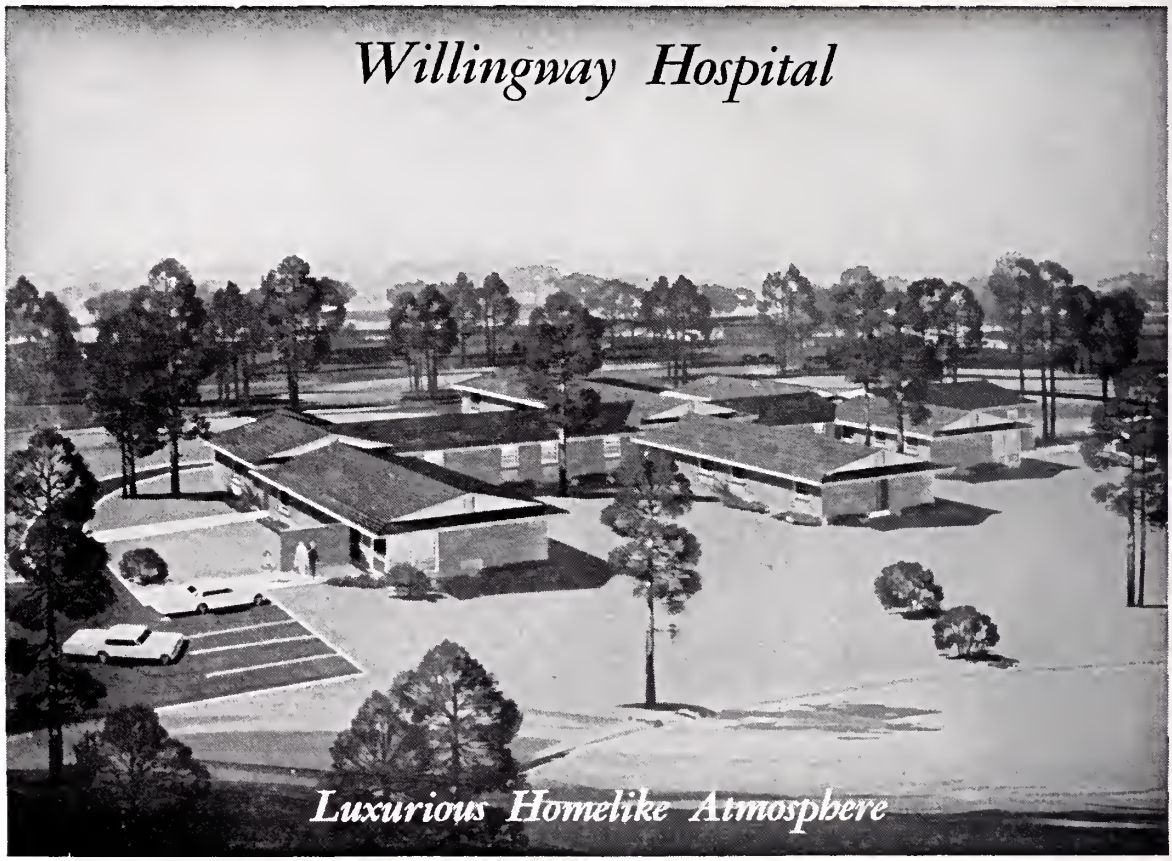

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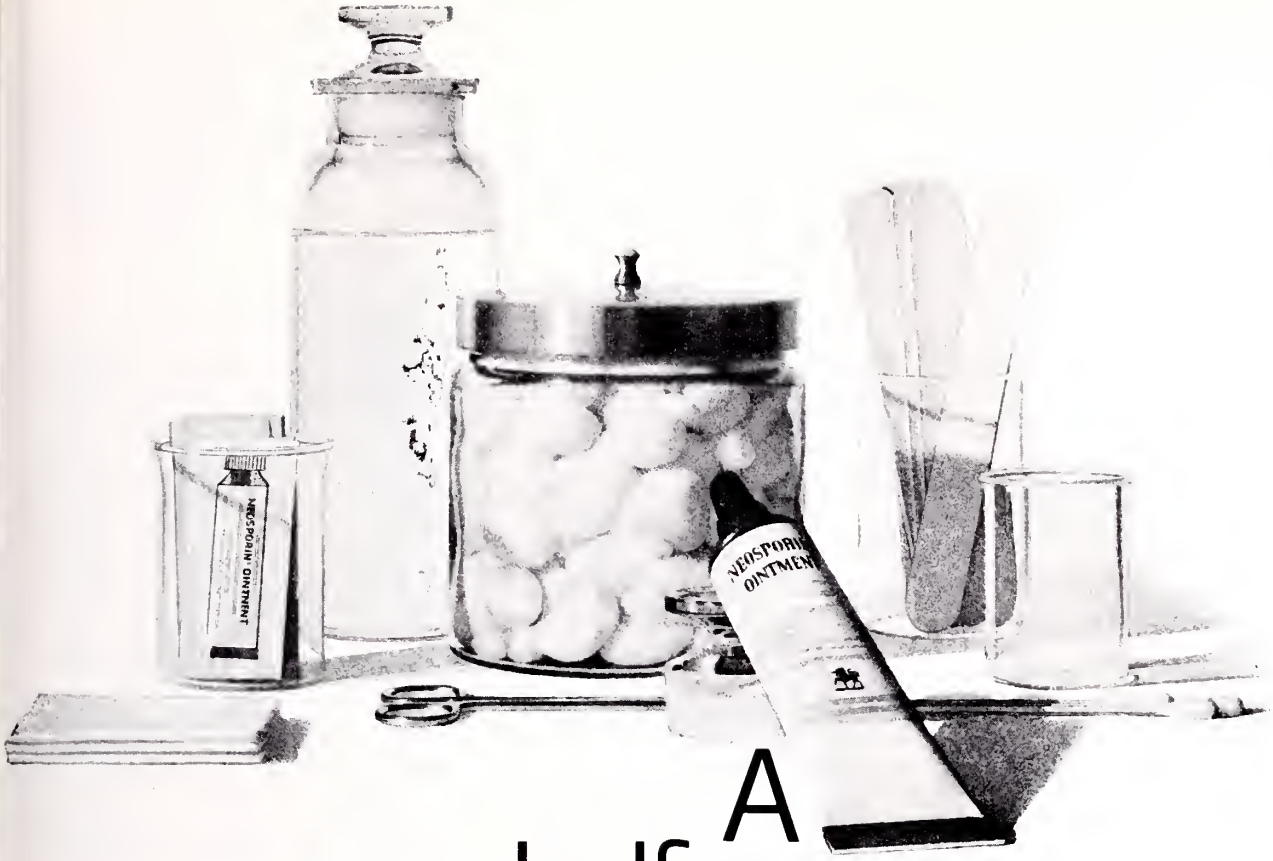

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ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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Blue Shield finds the Medicare B Program more difficult to administer than its private contracts because of the complex governmental regulations inherent in the program. The requirements for exact information are strict and the claims volume is by far larger than any other program administered by Blue Shield of Florida. Last year, the Part B volume was nearly 3.5 million claims; this year it is expected to reach about 4.5 million!

Many doctors, including me, are not exactly enthralled with the Medicare Program. It is cumbersome and restrictive and the regulations are many. It is difficult to understand and I feel that at times it intrudes on normal patient-physician relationships; however, take a few minutes to think about it. Whether we physicians like the Part B Program or not, whether we think the program is too cumbersome, whether we think the fee schedules are unrealistic, regardless of the countless government rules and regulations, we must first and foremost recognize that the Medicare Program is a law and our elderly patients covered under this law are entitled to payments for certain health care services. When our patients make use of their Medicare coverages, they, in turn, expect and deserve prompt claims service in order to get back the money they are entitled to under the law.

I urge that physicians have their office assistants prepare the Part B forms with all required information *even if the claim is unassigned.* If we do this for our patients, the chances are 10 times greater that the claim will be processed promptly and without delay. A recent study by Blue Shield of Medicare claims revealed that doctor-prepared claims had a 2.8% error rate compared to a 28% error rate when the patient attempted to prepare and submit his own claim form.

If the physician's office elects not to prepare the Part B claim form for the patients, the next best thing these office assistants can do is to make sure the "itemized bills" given patients contain *all* the necessary information required for "clean" processing of the claim. This information has already been mailed to doctors' offices by Blue Shield on these essential requirements.

Special free folders, *"For the Medicare Patient Who Fills Out His Own Claim Form,"* are available from Blue Shield which stress these essential items needed for the Part B claims to be processed trouble-free. The response by Florida physicians in helping distribute these folders to their patients is gratifying—over 2,000 physicians have asked for 500,000 folders. To me, this is real evidence of the medical community's concern for the patient's welfare.

To each and every physician in the state, I strongly urge your full cooperation in seeing that your Medicare patients get the information they need in order to better assure prompt and efficient claims servicing. The Part B claims servicing problem in this state is a very real and alarming one. Unquestionably, our senior citizen patients need our professional care. Providing that let's do all we can to make certain they get their insurance payments as promptly as possible.

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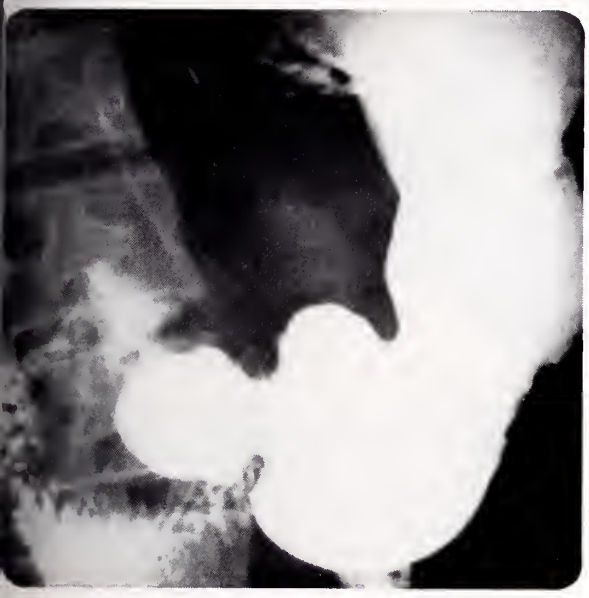
The Upper Functional G.I. Disorder

The Pseudo-ulcer

Ulcer-like symptoms: no G.I. pathology



X-ray demonstrates normal stomach.

The patient is convinced he has an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses. Please consult the complete product information regarding precautions and adverse reactions.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders: clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W.B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

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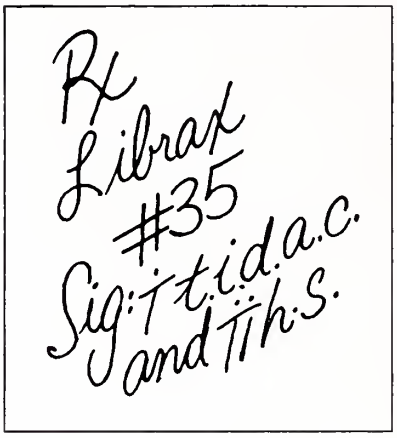

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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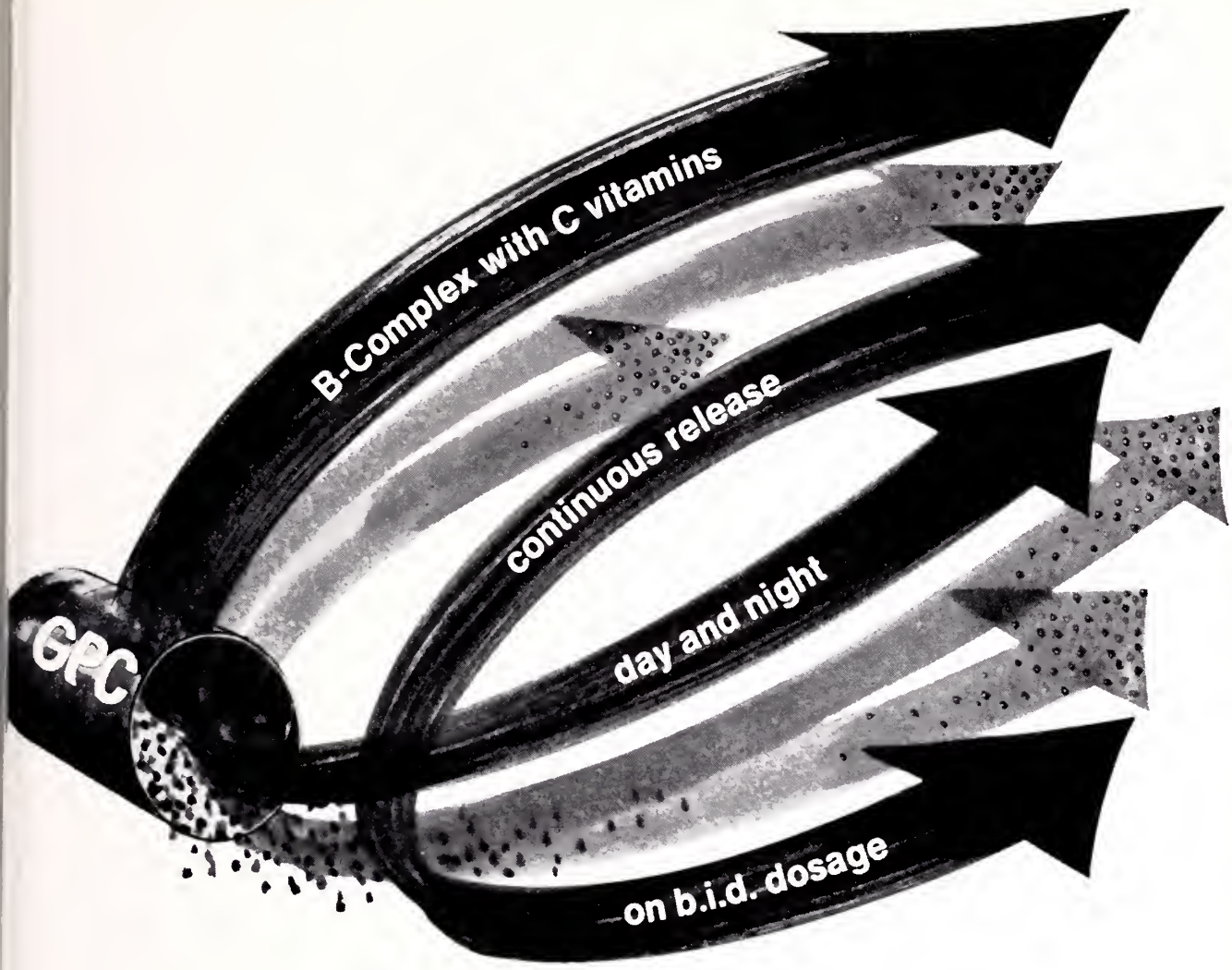

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

NOVEMBER

Current Topics in Endocrinology-Hypoglycemia: Fad or Fancy, Nov. 1, A. Vance Morgan Educational Center, South Miami Hospital, Miami

Florida Society of Internal Medicine, Nov. 1-3, St. Lucie Hilton, Stuart, Florida. For information: Mrs. Wanda L. McDermon, Florida Society of Internal Medicine, P.O. Box 2411, Jacksonville, Florida 32203.

Tumors in Children, Nov. 2, J. Hillis Miller Health Center, Gainesville**

Pediatric Pre-Football Game Seminar, "Tumors in Childhood," Nov. 2, J. Hillis Miller Health Center, Gainesville**

▶ Interstate Postgraduate Medical Association of North America, Nov. 4-7, Diplomat Hotel, Hollywood. For information: Mr. Roy T. Ragatz, Box 1109, Madison, Wisc. 53701

Seminar Session, Department of Anesthesiology, Feb. 3-7, University of Florida College of Medicine, Gainesville**

Cardiorespiratory Problems in the Pediatric Patient, Nov. 9, University Hospital of Jacksonville Auditorium, Jacksonville**

Pediatric Pre-Football Game Seminar, "Cardiorespiratory Problems in the Pediatric Patient," Nov. 9, University Hospital of Jacksonville Auditorium, Jacksonville**

Seminar in The Treatment of Sexual Dysfunction, Nov. 14, Riverside Hilton Hotel, Tampa

Intensive Workshop — How to do Acupuncture, Nov. 14-16, Gainesville Hilton, Gainesville**

Seminar in Professional Use of Films for Sex Education and Therapy, Nov. 15, Riverside Hilton Hotel, Tampa

Hand Surgery—1974, Nov. 15-17, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Miami*

Courses of Instruction in Coronary Care, Nov. 11-16, Jackson Memorial Hospital Coronary Care Unit, Miami*

▶ American Association for Clinical Immunology and Allergy, Nov. 21-24, Pier 66, Ft. Lauderdale. For information: John L. Dewey, M.D., P.O. Box 912, DTS, Omaha, Nebraska 68101

Leukemia-Lymphoma Conference for Physicians, Nov. 22, Host Airport Hotel, Tampa**

First Annual Coronary Artery Seminar, Nov. 22-23, Hilton Hotel, Gainesville

Weekend in Pulmonary Medicine, Nov. 23-24, St. Vincent's Medical Center, Jacksonville. For information: Gerald Olsen, M.D., Dept. of Pulmonary Medicine

Progress and Prospects in Health Care Distribution Systems, Nov. 25-27, Fontainebleau Hotel, Miami Beach*

Perinatology and the High Risk Pregnancy/Pediatric Postgraduate Seminar, Nov. 26, Board Room, Tallahassee Memorial Hospital, Tallahassee

Pediatric Hematology, Nov. 30, J. Hillis Miller Health Center, Gainesville**

Pediatric Pre-Football Game Seminar, "Pediatric Hematology," Nov 30, J. Hillis Miller Health Center, Gainesville**

DECEMBER

The Primary Physician Looks at Human Sexuality, Dec. 5-8, Sheraton Four Ambasadors Hotel, Miami*

"Changing Concepts in Infectious Diseases for Obstetrics & Gynecology," Dec. 5-6, Hilton Hotel, Gainesville**

Current Topics in Endocrinology Growth Problems, Dec. 6, A. Vance Morgan Educational Center, South Miami Hospital, Miami

Florida Society of Plastic & Reconstructive Surgeons winter meeting, Dec. 6-8, Guadalajara, Mexico. For information: Ian Matheson, M.D., 4600 N. Habana, Tampa 33614.

▶ Southern Surgical Association, Dec. 9-12, Boca Raton. For information: W. Dean Warren, M.D., 1364 Clifton Rd., N.E., Atlanta, Ga. 30322

Courses of Instruction in Coronary Care, Dec. 9-14, Jackson Memorial Hospital Coronary Care Unit, Miami*

13th Biennial Cardiovascular Seminar—"Tools and Techniques of the Practicing Cardiologist," Dec. 12-14, Sheraton Four Ambassadors Hotel, Miami. For information: Thomas J. Noto Jr., M.D., 5080 Biscayne Blvd, Miami 33137

Fracture Bracing and New Orthotic Developments, Dec. 16-18, Miami Beach*

Rational Management of Patients, Dec. 26-28, Clearwater. For information: Virginia A. Church, Ph.D., 710 Magnolia Dr., Clearwater, Fla. 33516

JANUARY

12th Annual Postgraduate Seminar in Anesthesiology, Jan. 2-5, Hyatt House, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Rd., Miami Beach 33140

Pediatric Nephrology, Jan. 2-7, Americana Hotel, Miami Beach*

Complications in Anesthesiology, Jan. 3-5, Hyatt House, Miami Beach*

Current Topics in Endocrinology—Current Concepts of Graves Disease, Jan. 3, A. Vance Morgan Educational Center, South Miami Hospital, Miami

Clinic Nights, Jan. 6-8, Biscayne Medical Center, Miami*

Neuro-Ophthalmology Seminar, Jan. 6-9, Doral Hotel, Miami Beach*

Topics in Clinical Pediatric Neurology, Jan. 9-11, Hyatt House, Miami Beach*

Infectious Diseases: Treatment & Prevention, Jan. 9-11, Hyatt House Hotel, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Pathology of the Oral Cavity & Its Management, Jan. 10-11, Fontainebleau Hotel, Miami Beach*

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▶ National meetings being held in Florida.

Special Procedures in Diagnostic Radiology: Basic and New Information, Jan. 12-16, Miami Beach Hyatt House**

Courses of Instruction in Coronary Care, Jan. 13-18, Jackson Memorial Hospital, Miami*

Seminar Session, Department of Anesthesiology, Jan. 16-17, University of Florida College of Medicine, Gainesville**

9th Annual Postgraduate Seminar in Surgery, Jan. 16-18, Sutton Beach Hotel, Miami*

Emergency Cardiac Care, 1975, Jan. 16-18, Americana Hotel, Miami Beach. For information: Emergency Medical Services Symposia, Inc., 1200 N.W. 10th Ave., Miami 33136

Pediatric Dermatology Seminar, Jan. 16-19, Carillon Hotel, Miami Beach

Continuing Education in Pediatrics, Jan. 19-23, Diplomat Hotel, Hollywood. For information: Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155

Internal Medicine 1975, Jan. 19-24, Fontainebleau Hotel, Miami Beach*

1975 Ear Surgery Course, Jan. 20-22, Host Airport Hotel, Tampa International Airport. For information: J. Brown Farrior, M.D., 509 Bay St., Tampa 33606

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 22-25, Hyatt House, Miami Beach*

17th Annual Cardiovascular Seminar, Jan. 24-25, Don CeSar Resort Hotel, St. Petersburg Beach. For information: Co. Heart Association, Box 12407, St. Petersburg 33733

Diagnostic Radiology for the Emergency Department Physician, Jan. 26-31, Key Biscayne Hotel, Miami. For information: Richard L. Bean, M.D., Memorial Hospital of Jacksonville, Jacksonville

Human Disease Related to Food and Chemical Sensitivity, Jan. 29-31, Americana Hotel, Miami Beach*

20th Central Florida Medical Meeting, Jan. 29-Feb. 2, Contemporary Hotel, Lake Buena Vista (Orlando) For information: Orange County Medical Society, 800 N. Mills Ave., Orlando 32803

FEBRUARY

Seminar Session, Department of Anesthesiology, Mar. 3-7, Universtiy of Florida College of Medicine, Gainesville**

Florida Midwinter Seminar in Ophthalmology & Otolaryngology, Feb. 3-8, Americana Hotel, Miami Beach*

Current Topics in Endocrinology (CPC), Feb. 7, A. Vance Morgan Education Center, South Miami Hospital, Miami

Zoonoses in the Southeastern United States and Caribbean, Feb. 12-13, Florida Division of Health, Jacksonville. For information: Gerald L. Hoff, Ph.D., P.O. Box 210, Jacksonville 32201

First Annual Cancer Symposium, Feb. 19-22, Walt Disney World, Orlando. For information: Martha Bonar, 134 E. Colonial Dr., Orlando 32801

Courses of Instruction in Coronary Care, Feb. 17-22, Jackson Memorial Hospital, Miami*

Pediatric Behavior Management Conference, Feb. 21-22, Department of Pediatrics, University of Miami School of Medicine, Miami*

The Diagnosis and Treatment of Acute and Chronic Respiratory Failure, Feb. 24-28, Miami Beach*

Thromboembolism: Diagnosis and Treatment, Feb. 27-Mar. 1, Doral Hotel, Miami Beach*

Skin—1975: Modern Management of Common Skin Disorders, Feb. 27-Mar. 2, Miami*

MARCH

▶ Continuing Education in Contemporary Medicine and Surgery, Mar. 2-7, Americana Hotel, Miami Beach. For information: American Soc. of Contemporary Medicine & Surgery, 40 N. Michigan Ave., Chicago 60602

3rd Annual Postgraduate Seminar in Emergency Medicine, March 5-9, Hyatt House, Miami Beach. For information: John Davison, M.D., 1200 N.W. 10th Ave., Miami 33136

Postgraduate Seminar in Neurology, March 10-14, Fontainebleau Hotel, Miami Beach*

Hormones and Cancer, March 10-14, Americana Hotel, Miami Beach*

Hypertension, Diabetes and Hyperlipidemia in Childhood, March 11-14, Americana Hotel, Miami Beach*

Clinical Radiology Seminar, March 18-22, Hyatt House, Miami Beach*

Seventh Teaching Conference in Clinical Cardiology, March 19-22, Sheraton Four Ambassadors Hotel, Miami*

Topics in Internal Medicine, Mar. 20-22, Gainesville Hilton, Gainesville**

Eighth Annual Instructional Course in Surgery of the Hand, March 21-23, University Hospital, Jacksonville. For information: Ira M. Dushoff, M.D., 824 Margaret St., Jacksonville 32204

Hypertension, Diuretics and Renal Disease, March 24-25, Sheraton Four Ambassadors Hotel, Miami*

APRIL

Seminar Session, Department of Anesthesiology, Apr. 7-11, University of Florida College of Medicine, Gainesville**

Fracture Bracing Workshop, Apr. 12-13, Miami*

Courses of Instruction in Coronary Care, Apr. 14-19, Jackson Memorial Hospital, Miami*

▶ Geriatric Medicine 1975, Apr. 16-17, Sutton Beach Hotel, Miami. For information: American Geriatrics Soc., 10 Columbus Circle, New York 10019

15th Workshop in Electrocardiography, Apr. 24-28, Tides Hotel, Redington Beach-St. Petersburg. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

Program for Foreign Medical Graduation, Apr. 28 & July 24, Sheraton Four Ambassadors Hotel, Miami Beach*

MAY

25th Annual Postgraduate Seminar, May 1-3, Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

An Intensive Day in Intensive Care, May 3, VA Hospital, Miami*

Seminar Session, Department of Anesthesiology, May 5-9, University of Florida College of Medicine, Gainesville**

Master Approach to Cardiovascular Problems, May 15-17, Walt Disney World, Orlando*

The Spinal Cord Injured Patients, May 16, Miami*

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Other Approved CME Meetings

Neonatal Care — 1974 (Wednesday) 7:30 p.m.-10:00 p.m., Tampa General Hospital, Tampa

Pediatric Grand Rounds (Friday, holidays excluded) 9:15 a.m.-10:00 a.m., University Hospital, Jacksonville

Pediatric Conference (Wednesday) 9:15 a.m.-10:00 a.m., Jacksonville Children's Hospital, Jacksonville

Graduate Level Courses in Family Practice (Weekdays), University of Miami School of Medicine*

Weekly Teaching Conference (Tuesday), Morton E. Plant Hospital, Clearwater

Peer Teaching Conferences (Wednesday), St. Vincent's Hospital, Jacksonville

In-Service Tutorial in Pediatric Cardiology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Neonatology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Radiology (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer Diagnosis & Treatment (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer In-Hospital Training Program (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Otolarynology (Arranged), University of Miami School of Medicine*

Grand Rounds in OB-Gyn. (Friday) 8 a.m., Conference Room, Second Floor, Tampa General Hospital, Tampa

Consultant Teaching Seminars, Family Practice (Weekly, Alachua General Hospital, Gainesville

In-Service Training in Family Medicine (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Cardiology (Arranged), University of Miami School of Medicine*

Courses of Instruction in Coronary Care for Practicing Physicians (Arranged), University of Miami School of Medicine*

Practical Aspects of Family Medicine (Arranged), University of Miami School of Medicine*

Cardiac Conference (Tuesday) 4:30 p.m.-5:30 p.m., North Florida Regional Hospital In-Service Classroom, Gainesville

Clinical Pharmacology Lecture Series, 8:30 a.m., 4th week of each month, Sept. 1974—May 1975, Memorial Hospital, Hollywood

Tuesday Evening Lecture Series, Department of Anesthesiology, Time: 5-6 p.m. Nov. 19; Dec. 17; Jan. 21; Feb. 11; Mar. 11; Apr. 15; May 13, Jackson Memorial Hospital, Miami

Visiting Professor Schedule, Department of Anesthesiology, University of Miami School of Medicine, Miami* — Nov. 18-20; Dec. 16-18; Jan. 20-22; Feb. 10-12; Mar. 10-12; Apr. 14-16; May 12-14

Weekly Teaching Conferences: Radiology, Wednesday, 8:15-9:15 a.m.; Pathology, Thursday, 11:00-12:00 noon; Staff Conference, Friday, 8:15-9:15 a.m.; Variety Children's Hospital 6125 S.W. 31st St., Miami 33155

Family Practice Conference (Tuesday), Bayfront Medical Center Conference Room, St. Petersburg

Neurology Workshop (Wednesday), A. Vance Morgan Educational Center, South Miami Hospital

Pulmonary Disease Processes (Wednesday), South Miami Hospital, Miami

Medical/Surgical Conference (Thursday), Bayfront Medical Center Auditorium, St. Petersburg

Hematology/Oncology Conference (Every other Thursday), Bayfront Medical Center Auditorium, St. Petersburg

Medical Office Management (Every other Thursday), Halifax Hospital Medical Center, Daytona Beach

Dialogue (Friday), A. Vance Morgan Educational Center, South Miami Hospital

Clinical Pathological Conference (Every 3rd Friday), A. Vance Morgan Educational Center, South Miami Hospital, Miami

Saturday Morning Chest Conference, Physicians' Library, Alachua General Hospital, Gainesville

Classified Ads

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Family Practitioners

WANTED—Family practitioner to join established physician in busy two-doctor practice. Salary and/or percentage first year with PA benefits. Lower Florida East Coast. Phone (305) 732-2701.

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FAMILY PRACTITIONER (AAFP qualified) wanted for north Florida college town. Busy practice in spacious, new two-man office building one half block from hospital. Enjoy getting out of the big city. Contact W. J. Bibb, M.D. (age 43), P.O. Box 179, Madison, Florida 32340. Phone Collect: (904) 973-6561.

WANTED: GENERAL PRACTITIONER to work in well equipped clinic in association with three family physicians, cardiologist and radiologist. Guaranteed minimum salary of $40,000 a year with potential of becoming full partner. Write Robert R. Tate, M.D., 4537 Coronado Parkway, Cape Coral, Florida 33904.

GENERAL PRACTICE: Fort Walton Beach multi-specialty group seeking physician to join two man department in fee-for-service practice. Guaranteed income plus percentage leading to partnership. New hospital just opened; new clinic building under design. Contact J. C. Wilson, M.D., P.O. Drawer M-M. Fort Walton Beach, Florida 32548, Phone (904) 243-7641.

GENERAL PRACTICE: Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

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MIAMI, FLORIDA AREA. Seven man multi-specialty, fee-for-service group is seeking an internist to join the group. Generous first year profit guarantee. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

PSYCHIATRIST for hospital and office practice in Florida's most prosperous city. Seven psychiatrists will welcome you. New 75-bed hospital underway. Office space available. Contact Robert G. Head, M.D., 1630-A North Plaza Dr., Tallahassee, Florida 32303.

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Miscellaneous

Family Practitioner, Otolaryngologist, Pediatrician, Internist-Rheumatologist, and Internist-Pulmonary Disease needed for outstanding practice opportunities. Forty-six physician medical group, affiliated with 312 bed hospital, located on Florida's Gulf Coast. Population doubling in five years. Advantages of group practice combined with prerogatives of solo practice. Fee for service arrangement with substantial drawing account first year. No investment required. For full details, contact D. M. Schroder, Mease Hospital and Clinic, Dunedin, Florida 33528, telephone (813) 734-6365.

EMERGENCY PHYSICIANS (3), FAMILY PRACTITIONERS, INTERNIST, ENT & PEDIATRICIAN needed for Jackson Hospital, Marianna, Florida. Contact C. Elwin O'Steen, Administrator, 3rd Avenue, Marianna, Florida 32446.

MULTISPECIALTY 16-MAN GROUP in Aventura, North Miami Beach, needs a full time cardiologist and part time subspecialist in gastroenterology, neurology and endocrinology which can lead to full time. This is a quality, fee-for-service group in private practice and it is not an HMO or Medicare clinic. Aventura Medical Center. 2956 Aventura Boulevard, North Miami Beach, Florida 33162.

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INTERNIST OR GENERALIST WANTED to join two doctor practice in internal medicine and geriatrics. Beach area Fort Lauderdale. Florida license. Salary first six months, then partnership. Excellent hospital privileges. A. Joseph Pitone, M.D. and Louis L. Amato, M.D., 2600 N.E. 9th St., Fort Lauderdale, Florida 33304. Phone: (305) 564-7597.

EMERGENCY ROOM PHYSICIAN NEEDED to increase staff of new facility serving 900-bed general hospital in town of 40,000, in stable, attractive community in central Florida lake district. U. S. training and citizenship essential. Previous practice or advanced training will be given prime consideration. Wire or write John F. Flanagan, M.D., 1600 Lakeland Hills Boulevard, Lakeland, Florida 33801.

PHYSICIAN DIRECTOR WANTED: General medical outpatient clinic. Progressive college community in central Florida. Excellent opportunity for the right person. Training in Family Practice or Internal Medicine preferred, Florida license required. Salary commensurate with training and experience. Contact: Raymond W. Wright, Administrator, Alachua General Hospital, Gainesville, Florida 32602; or call collect (904) 372-4321.

PHYSICIANS WANTED: Family practitioners (GP), internist-cardiologist, E. R. physicians, psychiatrist. New professional building. No investment required. Contact Claude L. Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

INTERNIST OR FAMILY PRACTITIONER: To associate with busy family practitioner. Clinic type practice; Lab; X-ray, Ft. Myers Beach, Florida. Florida license required. Send particulars first letter to M. J. Hetman, M.D., 6875 Estero Blvd., Ft. Myers Beach, Florida 33931.

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POSITION WANTED: Physician, many years experience, in good health, available for hospital, private or institution service, southern Florida. Write C-656, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON, board certified, 33, married, Navy trained, four years experience, available July 1975. All offers considered. Curriculum vitae on request. Write C-657, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED INTERNIST-ENDOCRINOLOGIST, 29, Florida licensed, moving to Orlando area now, in either internal medicine or general medicine. Curriculum vitae sent on request. Write 11323 El Sendero Drive, San Antonio, Texas 78233. Phone: (512) 656-0316.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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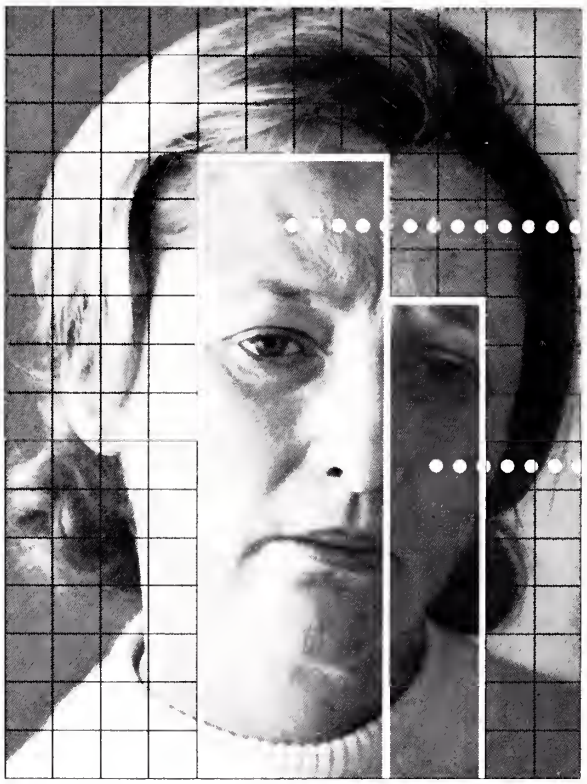
Malpractice Fever—A Social Disease (See page 866)

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequen and/or severity of grand mal seizures m require increased dosage of standard an convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous in gestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) hav occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

respond to one

According to her major ymptoms, she is a psychoneu- otic patient with severe ınxiety. But according to the lescription she gives of her eelings, part of the problem nay sound like depression. This is because her problem, ılthough primarily one of ex- :essive anxiety, is often accom- ɔanied by depressive symptom- ıtology. Valium (diazepam) :an provide relief for both—as he excessive anxiety is re- ieved, the depressive symp- :oms associated with it are also ɔften relieved.

There are other advan- tages in using Valium for the management of psychoneu- rotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that im- provement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In ad- dition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against haz- ardous occupations requiring complete mental alertness.

Also, because the psycho- neurotic patient's symptoms are often intensified at bed- time, Valium can offer an addi- tional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and asso- ciated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page

Fall Board Meeting Actions

Council and Committee reports presented at the fall meeting of the Florida Medical Association's Board of Governors were exciting because each indicated serious interest in the assigned task, purposeful involvement in striving for a conclusion, and much work by these dedicated physicians. The proposals and recommendations deserve careful consideration. A few of them are mentioned here.

Efforts continue in an attempt to fund a Peer Review Organization and so permit FMA-approved funds to be used to develop ideas and evolve plans that may be useful to each county medical society.

The Committee on Continuing Medical Education is preparing a scientific program for the 1975 FMA Annual Meeting which offers the interesting opportunity for each member to acquire the 20 mandatory hours of the 30 yearly required hours of continuing education.

Problems common to county medical societies is the subject of an audience participation discussion to be presented by the Committee on County Medical Society Presidents at the 17th Annual Leadership Conference for county society officers scheduled for January 25, 1975.

Intensive efforts have produced plans for presentation of two prefiled bills at the 1975 legislative session, one providing a Florida Department of Health Services and the other relief for patient and physician by changes in professional liability laws.

Studies are underway to collect the information necessary to support a revision of the Workmen's Compensation Fee Schedule. In this effort many of you may be requested to present testimony before legislative committees at the proper time.

The Committee on Relative Value Studies and Fee Schedules has reviewed the 1971 Relative Value Schedule and now is updating it. You should receive a new RVS listing in the spring of 1975.

Each four-year medical school reported on progress and future plans. It is good that we had this opportunity to learn of their successes and problems; we need the schools and the schools need our support. The University of Miami is returning to the four year curricula after a trial of the three year plan. The University of Florida is placing more emphasis upon the basic sciences in the first years of study. The University of South Florida will graduate its first class this month and is now developing graduate degree courses in the basic sciences.

Your Board of Governors is a hard working group of talented physicians dedicated to establishing a better medical climate for the State of Florida. Equally endowed with special abilities are the Council and Committee chairmen. This was adequately demonstrated by the reports presented at the Fall Board meeting.

Linda joins me in wishing each of you—and your family—a renewing Holiday Season and a healthy and rewarding 1975.

Thad Moseley

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Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
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No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

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No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

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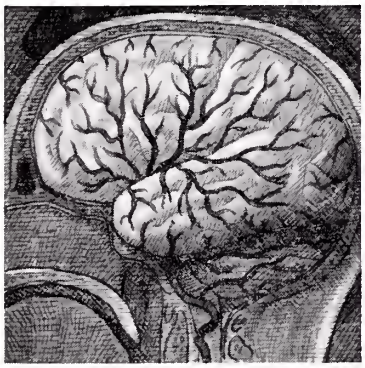

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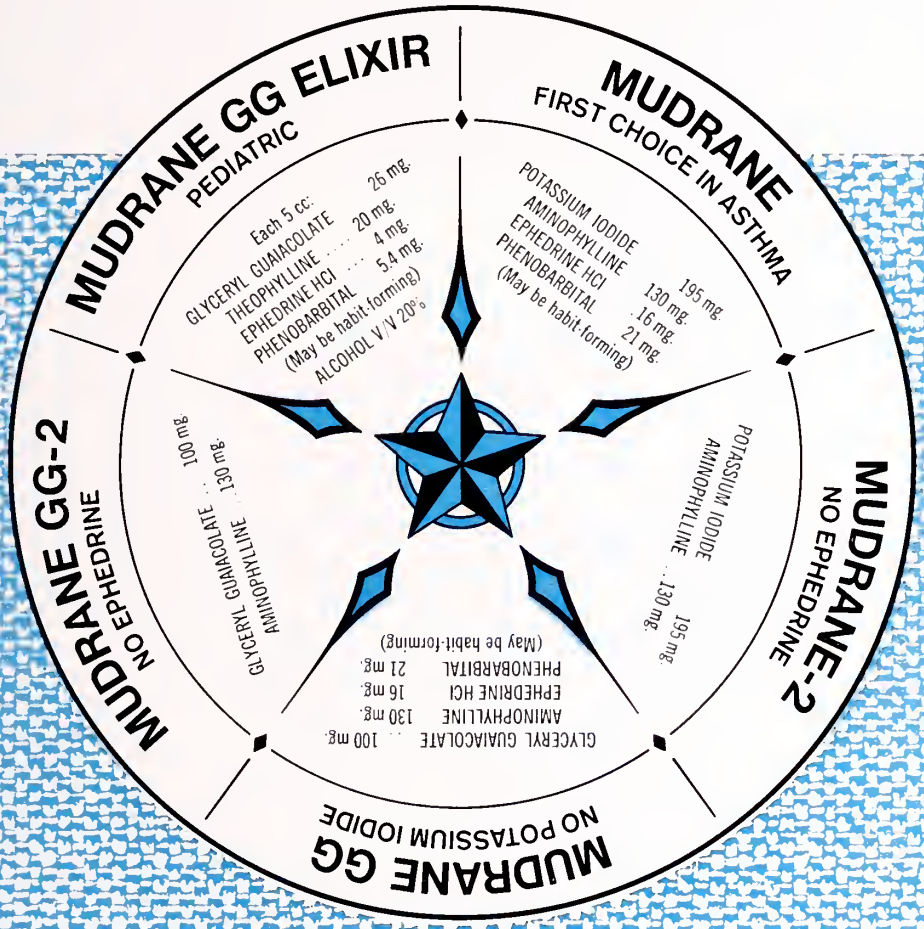

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

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Enuresis
Diagnosis and Management

R. DIXON WALKER, M.D.; FRANCIS A. DETURE, M.D.; ROBERT S. FENNELL, M.D., AND GEORGE A. RICHARD, M.D.

Abstract: The problem of enuresis continues to be a perplexing one not only to the parent and child but also to the physician. The etiology of enuresis is multifaceted and occasionally unclear. Diagnostic tools are available to elicit information in these patients so that therapeutic modalities may be applied. The gratitude of the parents in the enuretic child who is cured will greatly compensate for the time involved in their care.

Enuresis is one of the more common problems that presents to the family physician, pediatrician, or urologist for evaluation. Despite the voluminous literature on the subject, meaningful data that offer consistent advice regarding management and treatment are not easily obtainable. This article is not an attempt to review all of this data in depth, but rather an attempt to give an overview in perspective and then offer an approach to evaluation and treatment of the enuretic child.

Normal Voiding Patterns

To better understand enuresis, one needs to first look at the maturation of normal voiding patterns. Voiding in the infant is dependent on the intact reflex arc. Voiding occurs when there is sensory input from the stretched bladder into the cord resulting in a reflex motor response and detrusor contraction. As the child grows, his central nervous system pathways mature so that he develops control over urination. This is largely accomplished by maturation of inhibitory fibers. Once inhibition develops, the child is able to repress voiding and thus develops a greater bladder capacity. Inhibition appears to work even while sleeping. The age at which these fibers are fully developed is usually about the same time as those fibers which allow the child to walk—approximately two years of age.

Enuresis then is a failure to inhibit voiding while asleep or, more appropriately defined, involuntary voiding while asleep. There seems to be considerable question as to whether the patient is actually sleeping or awake at the time of voiding. Recent electroencephalographic studies have suggested that the enuretic child wets during light sleep, although classically, it has been felt that a deep sleep that ignores the sensations to void was responsible.

Incidence of Enuresis

Enuresis is a very common abnormality which may affect up to 20% of all children. It appears to be slightly more prevalent in males and crosses all socioeconomic barriers. It is of higher incidence in institutionalized children but appears to occur in all intelligence groups equally.

Etiology of Enuresis

Many physicians feel that enuresis is of psychological origin. Meredith Campbell[1] felt that it was largely due to the "persistence of infantile traits" that are brought on by prolonged dependence on parents. This was manifested in part by the child's desire to "get back" at the parents or the attempt to gain attention. Other concepts commonly associated with enuresis are that the child is parentally over-protected, parentally under-protected, or emotionally insecure. The atti-

From the Pediatric Renal-Urology Unit, University of Florida College of Medicine, Gainesville.

tude that this is largely a psychological problem has led many physicians to avoid treating enuresis.

The small bladder has been implicated by Muellner[2] as a cause for enuresis. There is little question that if one has a small bladder capacity then the urge to void will occur more often at night. This, however, does not completely explain enuresis, since one would expect the person with a neurologically intact bladder of small capacity to complain more of nocturia rather than enuresis. This patient should be able to inhibit a detrusor contraction and if not should wake to void. Troup[3] has shown that enuresis is at least not due to nocturnal polyuria since there was no difference in nocturnal and diurnal bladder capacities.

Bladder outlet or urethral obstructions are still not fully defined and their relationship to enuresis is even further complicated. Undoubtedly, in both male and female children obstruction does occasionally cause enuresis. There is some question as to the incidence of bladder neck obstruction, midurethral stenosis, and meatal stenosis in female children. The controversy over the relationship between these alleged obstructions and urinary tract infection is such as to make any relationship to enuresis equally suspect.[4] Surely these lesions do exist but probably in much less incidence than some investigators are reporting.[5] They may either directly or indirectly be related to the enuresis in a small number of cases.

Data comparing the relationship between urethral obstruction and enuresis in the male are equally confusing. Mahoney[5] and Arnold[6] believe that the incidence of obstructive urethral lesions in the enuretic male is high and after relief of obstruction, symptoms improve. Mahoney advocates that 96% of enuretic males have urethral obstruction with 44% having posterior urethral valves. Many pediatric urologists question whether the incidence of obstruction, and particularly of posterior urethral valves, is that high. Several investigators, including Kunin[7] and W. A. Campbell,[8] specifically feel that the incidence of obstructive lesions of both males and females is very low and that even when corrected do not often affect the prognosis of enuresis.

Recent studies have indicated that a mild form of uninhibited neurogenic bladder may account for a large number of enuretics.[9] An uninhibited neurogenic bladder would be characterized by small capacity, frequency, urgency, urgency incontinence, and an elevated intravesical pressure—findings consistent with many of the manifestations of enuresis. The delayed maturation of inhibitory fibers with the persistence of an "infantile" bladder can easily account for the increased incidence of enuresis within families and the propensity for enuresis to resolve with time (after maturation of inhibitory fibers). Linderholm[9] found that 57% of enuretic patients had evidence of uninhibited contractions on cystometrogram. Faulty inhibition may be secondary to either delay in maturation or mild organic brain damage. Campbell,[8] utilizing the Bender-Gestalt test, found that 66% of enuretic children had some indication of mild organic brain disease. Electroencephalographic abnormalities in association with enuresis have been noted by many investigators.[10-13] These abnormalities have primarily involved changes in sleeping patterns; most commonly, immature sleep patterns, decreased proportion of REM (Rapid Eye Movement) sleep or spike and wave patterns suggesting epileptic foci. Developmental maturation is genetically determined and perhaps accounts for the high incidence of enuresis within families. This maturation may be delayed by environmental processes. Evardsen[14] has experimentally demonstrated that normal control of voiding depends on a spinal adaptation reflex with inhibitory qualities. Experimentally placed lesions in the central nervous system resulted in defects of bladder control similar to those seen in enuresis. These were, of course, accompanied by other organic neurological findings. The only reasonable solution to a "selective" loss of inhibition would be through delayed maturation, for if discernible organic lesions did exist, these would almost always be associated with other neurological findings.

It is apparent that there is no single cause for enuresis. Enuresis appears as a symptom of many different pathological processes, many of which cannot be well defined. In most instances, after adequate studies have been performed to assure that no correctable pathologic condition exists, enuresis is treated empirically.

Management of Enuresis

The enuretic child should probably not be completely evaluated until after four years of age. Prior to this, involuntary nocturnal voiding may well represent one end of the normal maturation spectrum. The enuretic child under six years of age should have a complete physical examination and urinalysis as should any child in this age group in well care follow-up. Urine culture should be done routinely as well because of the signif-

icant incidence of false negative urinalysis. If these findings are normal, one should not proceed further until after the child is six years of age. This landmark is an arbitrary one and must be tempered by the physician's judgment in regard to the situation. Physical examination involves not only a careful neurological evaluation but also a complete examination of the genitalia. Meatal stenosis is probably the most common finding in males on physical examination. One should do a meatotomy only if there is a good correlation between the size of the meatus, the size and velocity of the urinary stream, and voiding symptoms and these indicate an obstructive element. All male children with round meatus do not necessarily need meatotomies. The parents should be told that relieving the meatal obstruction may not relieve the enuresis.

Enuretic children over the age of six should have a more complete evaluation to rule out pathological causes of their enuresis. In our practice after we have completed a thorough history, physical examination, urinalysis and culture, we proceed to radiological examination. Males should have an intravenous pyelogram with a voiding film. It would be most appropriate to obtain a voiding cystourethrogram at the same time as the cystometrogram so that the male child would only have to be catheterized one time. This is not always technically feasible and if the IVP and voiding film are completely normal one may elect to bypass the voiding cystourethrogram. If there is even the slightest question of pathology, however, a voiding cystourethrogram should also be obtained. Our concern over male catheterization arises because a small but significant number of iatrogenic strictures may be related to urethral instrumentation. In all female patients we obtain a voiding cystourethrogram followed by an intravenous pyelogram. We do not cystoscope our patients unless there is pathology seen on radiological examination or other indications for cystoscopy arise (i.e., severe recurrent urinary tract infections). After radiological evaluation the child has a cystometrogram. The Merrill Air Cystometer* is probably the best apparatus for use in a child but in its absence a spinal manometer can be used quite satisfactorily. The residual urine should first be measured after introduction of a small caliber catheter. Pressures in the bladder can then be measured in association with bladder filling. If the child is cooperative, then one can also elicit sensations of hot and cold. It is most important to look for evidence of uninhibited contractions since this may give the only clue to an uninhibited neurogenic bladder.

Treatment of the enuretic child is based largely on empirical findings but also has some rational basis. Obviously if the child has evidence of an organic lesion, this should first be treated to see if there is a response to his enuresis. Pathological findings may only be coincidental and the child many continue to have enuresis even after relatively severe pathological processes are surgically corrected.

The experience with imipramine leaves little question that it improves a significant number of children with enuresis.[15,16] Imipramine should not be used in children under six years of age. All enuretic children that we see are followed at three monthly intervals and those on imipramine are checked carefully for side effects. Imipramine appears to have three possible modes of action: antidepressant effect, parasympatholytic effect, and an increase in awareness. Imipramine does seem to have its best response in patients with evidence of uninhibited contractions suggesting that the parasympatholytic effect may be the most important one. We empirically try all children over age six with enuresis with imipramine but if there is no response within three months, then the drug is discontinued. The patient having a relatively severe uninhibited neurogenic bladder may need other parasympatholytic drugs in order to complete treatment. In our practice we have used propantheline bromide during the day and before bedtime. This has largely been used in patients with daytime incontinence as well as enuresis.

The pharmacologic treatment of enuresis makes up only one facet of treatment and is probably the least demanding on the physician. Many of the enuretic children can become very physician-dependent and some dependency may be beneficial in relieving enuresis. We usually begin all children on a planned program with built-in incentives. This includes: 1. Little or no fluids after dinner, 2. Waking to void when the parents go to bed, 3. Stretching the bladder during the day by practicing holding the urine for longer periods of time, and 4. Daily charts with awarding of "stars" for dry nights. The enuresis calendar is kept by the patients and is presented to the physician at the regular visit. This calendar is important for two reasons. First, it makes the child concentrate on a daily basis on staying

*Merrill Air Cystometer—Burbank Medical Instruments, 7746 S. Laramie, Burbank, Ill. 60459

dry. Second, it gives the physician his best index of results; that being the number of dry nights per week.

If neither the pharmacological or supportive therapy relieves the enuresis then we proceed to awakening devices. We discourage costly investments into those measures which are always available for those patients looking for an "instant cure." Several manufacturers* have awakening devices that can be purchased at a modest cost.

There are always a certain number of enuretic children who are not helped by any of the methods previously discussed. On occasion, we have reinstituted chemotherapy at a later date and a previously unresponsive child this time will have good results. Some children may have predominantly psychological problems causing their complaints and in these instances consultation with a child psychiatrist can be helpful. Unfortunately, child psychiatrists are few in number and are extremely busy so that this avenue of approach is not always feasible. In a segment of the enuretic population, one must be honest with the parents and explain that everything has been done that is reasonable and yet the enuresis is not abated. The physician can reassure the parents that in most instances this problem will resolve by adolescence.

*Sears, Roebuck and Co.

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Warnings: Lactic Acidosis: There have been numerous reports of lactic acidosis in patients receiving phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, an increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, azotemia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings:

a. Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum creatinine, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function.

b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.

c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy. Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.

d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.

e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.

f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.

Pregnancy: Use during pregnancy is to be avoided.

Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake. *"Destabilization" of Previously Controlled Diabetic:* When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.

Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

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Special Article

Malpractice Fever—A Social Disease

The Florida Medical Association entered into a contract with the Argonaut Insurance Company to underwrite its Professional Liability Insurance Plan effective January 1, 1973. This was accomplished when the Employers Insurance Company terminated underwriting the program after ten (10) years with an anticipated loss in excess of $12,000,000.

The FMA program is unique in that it provides for centralized claims handling, centralized coordination of legal defense, centralized administration of all aspects of the program with the Medical Association's active participation, Medical Society determination of "chargeable losses" of individual physicians, complete financial disclosure of the program and active defense of all non-meritorious suits. In addition the program has guaranteed underwriting by the Argonaut for a minimum of five years subject to adequate rates.

Premiums for professional liability insurance under this program will increase approximately 75% effective January 1, 1975. THE ACTUAL INCREASE WILL BE 66% IN DADE AND BROWARD COUNTIES AND 84% IN THE REMAINDER OF THE STATE. Currently Dade and Broward physicians are paying twice the premium rate charged in the remainder of the state.

Insured physicians will be allowed "emergency medical expenses" at no additional premium charge. This additional medical expense coverage is for prompt payment by the attending physician covering medical expense to or for a person sustaining an injury or maloccurrence arising out of medical treatment not necessarily attributed to negligent conduct. The annual aggregate amount of liability for which a physician can be reimbursed is $5,000.

In my opinion, the drastic increase in the number of incidents and cost of claims is a reflection of the social evolution where malpractice is being used by claimants for life insurance benefits, disability insurance benefits and health insurance benefits, none of which professional liability insurance was intended to cover.

The following article has been prepared by two outstanding authors in this field to provide background and factual data regarding the program. Legislation to be sponsored by the FMA in an attempt to ease the malpractice suit crisis is also summarized.

The primary author is Leyton B. Hunter, President of the London Agency, who has been a consultant and associated with the Florida Medical Association insurance programs for twenty years. He is recognized from both an insurance standpoint and actuarial data pertaining to our program.

Francis P. Conroy, Esq., is the managing partner of Marks, Gray, Conroy & Gibbs, a Jacksonville law firm. This firm of recognized defense attorneys are coordinating attorneys for the Professional Liability Insurance Program and has represented the Association for over 50 years.

W. Harold Parham, D.H.A.
Executive Vice President

STATUS, TRENDS, AND ACTION PROGRAM

This is a summary report on the FMA Professional Liability Insurance Plan, which has so effectively served the membership for eleven years. But for the strength gained from a common front, some of these would have been years of crisis for many of our members. By standing together and pooling purchasing power, the program has become a model for stability, continuity, effective claims resistance, and cooperation between the FMA and the insurance carrier.

While the program has functioned remarkably well for FMA members, it has been costly for the FMA Professional Liability Insurance Plan and may partially explain the mass exodus of companies writing this insurance for Florida.

*** The actual amount was still being negotiated at press time.**

THE RECORD—PERTINENT FACTS

1963 to June 30, 1974

1. Number Insured:

1963— 390	Physicians
1968—2297	"
1973—4448	"
1974—5000	"

2. Claims:

2193	Paid—Cost	$13,499,286
808	Pending—Reserve	14,373,551
1696	Anticipated*	22,048,000
	TOTAL	$49,920,837

*Note: For claims yet to be reported under policies issued in 1974 and prior years.

3. Premiums:

All-time	$27,925,754	
Less Expenses—20%	5,585,150	
	$22,340,604	
Plus Anticipated Investment income, 20%	4,468,120	
	$26,808,724	$26,808,724

4. Underwriting Loss:

All-time	($23,112,113)

PREMIUM VALIDATION—GEOGRAPHICAL AND SPECIALTY CLASSIFICATION

An indepth study confirms no significant disparity in either the geographical or specialty classification. The tables below show the facts.

TERRITORIAL

	Premiums	*Losses*
Dade & Broward	56%	52%
Remainder	44%	48%

SPECIALTY

Class	*Premiums as % of Total*	*Reported Claims as % of Total*
1	17%	16%
2	5%	6%
3	10%	9%
4	25%	23%
5	43%	46%

The Insurance Industry

Because of changing social attitudes, changing judicial generosity, the constantly increasing frequency of claims, the constant enlargement of the average value of each claim, and the inability of insurance in the past to adequately set premiums to anticipate inflation, the industry has become disenchanted with this type of insurance.

Although New York has apparently solved their problem for the time being with a 93.5% rate increase, many underwriters question the adequacy of rates even with the increase.

Rate increases for professional liability insurance are currently being sought country-wide by the industry. Typical are the following states:

Alabama	— 100%
Louisiana	— 100%
Maryland	— 250%
North Carolina	— 200%
South Carolina	— 100%
Tennessee	— 250%
Virginia	— 100%

If granted, these premium increases do not mean that the insurance industry is prepared to write this type of coverage. In fact, all signs point to a shrinking insurance market because of other factors.

The insurance industry has not in recent decades been so battered by a combination of inflation, inadequate rates, and shrinking assets from the stock and bond market as it has this year. In 1972 the property/liability industry achieved an underwriting profit of about 1.2 billion dollars. In 1973 this diminished to about 20 million dollars. And for the first 6 months of 1974 the underwriting loss is approximately one (1) billion dollars; the industry projects an underwriting loss of 2 billion dollars. This loss is compounded by a reduction in assets estimated at about 6 billion dollars from a depressed stock and bond market.

Against this background, all marginal types of insurance will definitely be avoided. Professional liability insurance has historically been a "loser" in the industry, and thus a rapidly shrinking market can be anticipated.

Action Program

The FMA has recognized the underlying trends which can only mean continued increased premiums for its member physicians. It is also fully cognizant of the current adverse situation of the insurance industry. In an effort to seek answers to the basic problems a conference was held on September 30-31, and more than 20 persons responded to our invitation.

CAUSES OF CLAIMS

By Frequency		By Cost
1	Improper diagnosis or treatment—not involving surgery	2
2	Technical surgical error	1
3	Adverse reaction to drugs	4
4	All other	6
5	Improper treatment of fractures	5
6	Improper anesthesiology	3
7	Injury from fall during examination	12
8	Foreign body left in patient following surgery	7
9	Tooth damage during anesthesia	16
10	Infection in surgical site	9
11	Injury from equipment—including x-ray	10
12	Injury to child in childbirth	8
13	Error of an employee	14
14	Personal injury (libel, slander, etc.)	18
15	Abandonment	15
16	Injury to mother in childbirth	11
17	Disfigurement from surgery	13
18	Assault (Generally operating without prior permission)	17
19	Contractual (Not getting result promised patient)	19
20	Lack of informed consent (sole factor)	20
21	Injuries or infections from blood transfusions	21

THE TREND—FMA PLAN

Claim Claims per 100 insured physicians

Frequency:	*Policy Year*	*Actual*	*Projected*
	1963	5.13	—
	1964	6.56	—
	1965	9.62	—
	1967	15.74	—
	1969	11.54	13.0
	1971	10.71	13.8
	1973	7.67	16.5
	1975	—	18.5

Claims Paid Amount:	*Year Paid*	*No.*	*Average Amount*
	1965	17	$1,182
	1967	67	1,619
	1969	188	3,330
	1971	281	6,929
	1973	431	9,752

Representatives of the FMA, AMA, Florida Insurance Department, insurance agents and brokers, insurance underwriters, insurance claims people, and defense attorneys were present. This group represents the highest competence in their respective fields.

AS AN OUTGROWTH OF THIS MEETING A LEGISLATIVE PROGRAM WAS APPROVED BY THE BOARD OF GOVERNORS FOR EARLY ADOPTION BY THE FLORIDA LEGISLATURE AND WILL INCLUDE BILLS TO AMEND THE FLORIDA STATUTES BY:

1. Defining Informed Consent similar to a Georgia Law:

   "*A consent* to medical and surgical treatment which discloses in general terms the treatment or course of treatment in connection with which it is given, and which is duly evidenced *in writing* and signed by the patient or other person or persons authorized to consent pursuant to the terms hereof, *shall be conclusively presumed to be a valid consent in the absence of fraudulent misrepresentations* of material facts in obtaining the same."

2. Providing no guarantee of results of treatment may be valid and enforceable unless in writing.

3. Revising the Statute of Limitations to prohibit suits after two years from date of incident or one year from date of discovery whichever occurs later, but in no event shall exceed four years. Current law is two years from date of incident or discovery plus two years.

4. Defining Res Ipse Loquitur similar to the Alaska Law.

   Section 1. In professional liability actions against physicians and surgeons, dentists, or licensed hospitals, *there shall be no presumption* or inference of *negligence* on the part of any defendant.

   Section 2. In professional liability actions against physicians and surgeons, dentists, or licensed hospitals, the jury shall be instructed that the *plaintiff has the burden of proving, by a preponderance of the evidence, the negligence* of the defendant or defendants. The jury shall be further instructed that injury alone does not raise either a presumption or an inference of negligence.

5. Placing a Limitation of Contingency fee arrangement in negligence cases to that amount in effect in New Jersey—50% on the first $1000 recovered, 40% on the next $2000 recovered, 33⅓% on the next $47,000 recovered, 20% on the next $50,000 recovered, 10% on any amount recovered over $100,000, 25% on the first $50,000 if the recovery is a settlement without trial for an infant or incompetent. This will also include an accounting to the courts for advanced costs.

6. Prohibiting the Ad Danmum Clause

7. Amend the Liability Reporting Law to further restrict use of name of physician sued.

THE BOARD OF GOVERNORS ALSO DIRECTED AN INDEPTH STUDY OF COMPENSATION PROGRAM (NO-FAULT), MANDATORY ARBITRATION (PENNSYLVANIA), MANDATORY MEDIATION PANEL (NEW YORK), JOINT HOSPITAL-PHYSICIAN PLI PANELS, AND OMBUDSMAN, COLLATERAL SOURCE RULE (DUPLICATE SOURCE).

Others Are Saying

MEDICAL MALPRACTICE

Smith Calls On Doctors For Joint Effort

Conditions under which medical malpractice insurance is marketed and serviced have eroded to the point where coverage will be unavailable in some areas by 1975 and "the only source of financial protection . . . will be a government system," according to St. Paul F&M president Waverly G. Smith. He called on members of the American Academy of Ophthalmology and Otolaryngology to undertake a joint effort with the insurance industry to solve the "malpractice claims crisis." St. Paul announced last June that it would terminate its policy with the Medical and Chirulogical Faculty of Maryland effective January 1, 1975.

Recent changes in negligence procedural law have eroded traditional legal defenses, Mr. Smith noted, urging that insurers and doctors consider what remedial legislation is necessary to prevent the complete collapse of legal defenses. "You, the public and legislators must recognize that doctors cannot be expected to be infallible, and there must be some protection under the law."

Mr. Smith suggested that the medical profession "determine what your local legal situation is (and) set a course of action to correct the problems you are facing. . . . Action at this point is more important than words. Time is running out in terms of an available and free market for medical malpractice insurance."

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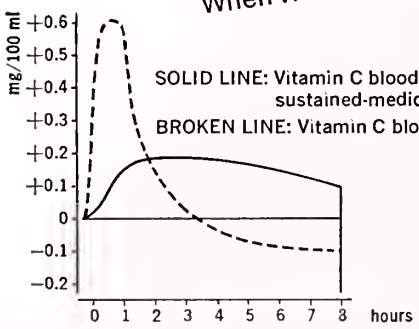

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*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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Editorial

Christmas 1974

Approaching is the supreme holiday of children and of families the world over. Spiritually and materially it is a day of new beginnings, of light and warmth and the revival of hope. It is not only a date in time but a day by which we mark our calendar years; a recurring festival, it is an experience of the human heart. Centuries old and vividly colored by ancient thoughts and custom, it is as new and fresh every year as the universal hope it represents. In the northern hemisphere its midwinter date gives it a special character so that its very name conjures up a picture of frost and snow and evergreen, of fires and candlelight indoors and of the first almost imperceptible lengthening of daylight hours outside.

To Christians it is more than a holiday, more than feasting festivity, tinsel and toys; for underneath all the outward glitter and gaiety is the secret that makes the season glow. That secret is the sharing of ourselves and what we have with others, for Christmas after all is what we make it in our own hearts. Christmas has to do with people transcending the artificial barriers of color, race or formal religion. Christmas is love for all humanity, compassion for the sick, respect and dignity for the aged and in every new baby's cry a hope that this spirit of thinking more of others will be with us forever and ever.

While nations of the world "have grasped the mystery of the atom but rejected the Sermon on the Mount, achieved brilliance without wisdom, power without conscience, become nuclear giants and ethical infants, knowing more about war than peace, more about killing than living:" Christmas may be only a short respite from the everyday trials of working and surviving. And, finding no evidence for an instinctional cause of aggression, anthropologists maintain that it is the result of frustration stemming from childhood experiences and the influence of helplessness and powerlessness during infancy. This prolonged stage of immaturity renders the child susceptible to deprivation and trauma and abets his sense of dependency, which on reaching adulthood in today's society is transformed into a paranoid state by social and political forces. This would not necessarily follow, if that which we preach at Christmas time we put in practice the year round.

Moral rules that cannot be converted into psychological truths are misunderstood and often sound impossibly idealistic unless recouched in psychological terms. When examined more closely in this light we perceive the worth of the giving of gifts at Christmas. Born excessively needy, everything for survival must be supplied us for a long time so that when we are young it is a great delight to receive. Maturing, and in time becoming humane, means divesting oneself of this neediness. Only then on finding the keener pleasure in giving to others are we capable of a deeper permanent satisfaction. The saddest grown-ups are those materially and spiritually needy throughout life remaining as covetous and as grasping as when they were children, for this craving to take is by its nature insatiable and ultimately ungratifying. The act of giving can be a painful or a pleasant experience. Yet the simple generosities, the very heart of Christmas, contain powerful spiritual truths, in the searching for which can be found the tools to make Christmas a creative and inspiring experience. Gracious giving from the depths of the heart requires no special talent nor large sum of money. It is compounded of the head and the heart acting together toward the perfect expression of the spirit. It is love molded by imagination, and at its best is always a portion of oneself.

Why then does Christmas assume such an important place in our hearts and lives? Is it

because the image of a newborn babe piercing through to our deepest emotions forces us to consider the possibilities of perfect love and perfect peace? In Christian belief this child becomes human through a miraculous conception. The miracle of birth tells us that we have the power within ourselves to make life more meaningful, giving everyone a second chance to mold a new generation of mankind. As all life is a contest of light against darkness, joy against despair, so as we have faith that tonight the stars will shine and tomorrow the sun will rise, seeds sprout and flowers grow, why not believe that tomorrow will be better. For average people strengthened by faith do perform saintly deeds and heroic ones and man aspires and builds his hope into institutions that move forward even when he wearies.

At no time of the year do we demand or expect so incredulously what we do at this season. It is as if on this one day of the year we expect to put everything right. This fantasizing goes on at the subconscious level where usually we don't face up to its irrationality so when Christmas has come and gone we can't avoid a feeling of something lost. Christmas, like all times of great expectations, is a time of stress but it doesn't have to be if we stop expecting the impossible. The answer is not to take the magic out of Christmas but the self-deception out of ourselves.

C.M.C.

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Side Effects: May produce a discoloration of the urine. This is of no clinical significance. May appear in milk of lactating mothers.

Precautions: Frequent or prolonged use may result in dependence on laxatives.

Contraindications: Should not be used when nausea, vomiting, abdominal pain or other symptoms of appendicitis are present.

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It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses. Please consult the complete product information regarding precautions and adverse reactions.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders; clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W.B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

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ase see summary of product information on following page.

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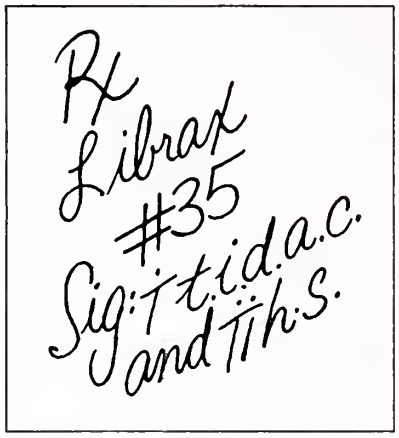

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Follow-up therapy

Follow-up therapy with a prescription for 2 to 3 weeks' medication usually helps maintain patient gains.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

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Charles E. Kossmann, M.D., Professor of Medicine, University of Tennessee College of Medicine, Memphis, Tennessee, Cardiovascular Diseases.

Charles H. Rammelkamp, Jr., M.D., D.Sc., Professor of Medicine, Case Western Reserve University School of Medicine, Cleveland, Ohio, Infectious Diseases.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

DECEMBER

The Primary Physician Looks at Human Sexuality, Dec. 5-8, Sheraton Four Ambasadors Hotel, Miami*

"Changing Concepts in Infectious Diseases for Obstetrics & Gynecology," Dec. 5-6, Hilton Hotel, Gainesville**

Florida Obstetric & Gynecologic Society, Dec. 5-8, Tarpon Springs. For information: George N. Lewis, M.D., Box 3488 M, Tallahassee 32303*

Current Topics in Endocrinology Growth Problems, Dec. 6, A. Vance Morgan Educational Center, South Miami Hospital, Miami

Florida Society of Plastic & Reconstructive Surgeons winter meeting, Dec. 6-8, Guadalajara, Mexico. For information: Ian Matheson, M.D., 4600 N. Habana, Tampa 33614

Traveling Seminars in Respiratory Care, Dec. 7, DeSoto County Middle School Auditorium, Arcadia. For information: Gordon H. McSwain, M.D., P.O. Box 930, Bartow 33830

▸ Southern Surgical Association, Dec. 9-12, Boca Raton. For information: W. Dean Warren, M.D., 1364 Clifton Rd., N.E., Atlanta, Ga. 30322

Courses of Instruction in Coronary Care, Dec. 9-14, Jackson Memorial Hospital Coronary Care Unit, Miami*

13th Biennial Cardiovascular Seminar—"Tools and Techniques of the Practicing Cardiologist," Dec. 12-14, Sheraton Four Ambassadors Hotel, Miami. For information: Thomas J. Noto Jr., M.D., 5080 Biscayne Blvd, Miami 33137

Non-Invasive Methods of Cardiovascular Diagnosis and Treatment, Dec. 13-15, Galt Ocean Mile Hotel, Fort Lauderdale. For information: Heart Association of Broward County, 440 North Andrews Avenue, Fort Lauderdale 33301

Fracture Bracing and New Orthotic Developments, Dec. 16-18, Miami Beach*

Infections by Anaerobic Organisms, Dec. 17, Martin Memorial Hospital Trailer Conference Room, Stuart*

Rational Management of Patients, Dec. 26-28, Clearwater. For information: Virginia A. Church, Ph.D., 710 Magnolia Dr., Clearwater, Fla. 33516

JANUARY

12th Annual Postgraduate Seminar in Anesthesiology, Jan. 2-5, Hyatt House, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Rd., Miami Beach 33140

Pediatric Nephrology, Jan. 2-7, Americana Hotel, Miami Beach*

Complications in Anesthesiology, Jan. 3-5, Hyatt House, Miami Beach*

Current Topics in Endocrinology—Current Concepts of Graves Disease, Jan. 3, A. Vance Morgan Educational Center, South Miami Hospital, Miami

Clinic Nights, Jan. 6-8, Biscayne Medical Center, Miami*

Neuro-Ophthalmology Seminar, Jan. 6-9, Doral Hotel, Miami Beach*

Topics in Clinical Pediatric Neurology, Jan. 9-11, Hyatt House, Miami Beach*

Infectious Diseases: Treatment & Prevention, Jan. 9-11, Hyatt House Hotel, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Pathology of the Oral Cavity & Its Management, Jan. 10-11, Fontainebleau Hotel, Miami Beach*

Newer Antibiotics, Jan. 21, Martin Memorial Hospital Trailer Conference Room, Stuart*

Human Disease Related to Food and Chemical Sensitivity, Jan. 29-31, Americana Hotel, Bal Harbour*

Special Procedures in Diagnostic Radiology: Basic and New Information, Jan. 12-16, Miami Beach Hyatt House**

Courses of Instruction in Coronary Care, Jan. 13-18, Jackson Memorial Hospital, Miami*

Seminar Session, Department of Anesthesiology, Jan. 16-17, University of Florida College of Medicine, Gainesville**

9th Annual Postgraduate Seminar in Surgery, Jan. 16-18, Sutton Beach Hotel, Miami*

Emergency Cardiac Care, 1975, Jan. 16-18, Americana Hotel, Miami Beach. For information: Emergency Medical Services Symposia, Inc., 1200 N.W. 10th Ave., Miami 33136

Pediatric Dermatology Seminar, Jan. 16-19, Carillon Hotel, Miami Beach*

Continuing Education in Pediatrics, Jan. 19-23, Diplomat Hotel, Hollywood. For information: Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155

Internal Medicine 1975, Jan. 19-24, Fontainebleau Hotel, Miami Beach*

1975 Ear Surgery Course, Jan. 20-22, Host Airport Hotel, Tampa International Airport. For information: J. Brown Farrior, M.D., 509 Bay St., Tampa 33606

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 22-25, Hyatt House, Miami Beach*

17th Annual Cardiovascular Seminar, Jan. 24-25, Don CeSar Resort Hotel, St. Petersburg Beach. For information: Co. Heart Association, Box 12407, St. Petersburg 33733

Diagnostic Radiology for the Emergency Department Physician, Jan. 26-31, Key Biscayne Hotel, Miami. For information: Richard L. Bean, M.D., Memorial Hospital of Jacksonville, Jacksonville

Human Disease Related to Food and Chemical Sensitivity, Jan. 29-31, Americana Hotel, Miami Beach*

20th Central Florida Medical Meeting, Jan. 29-Feb. 2, Contemporary Hotel, Lake Buena Vista (Orlando) For information: Orange County Medical Society, 800 N. Mills Ave., Orlando 32803

Current Computer Applications in Medicine, Jan. 31-Feb. 1,**

---

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▸ National meetings being held in Florida.

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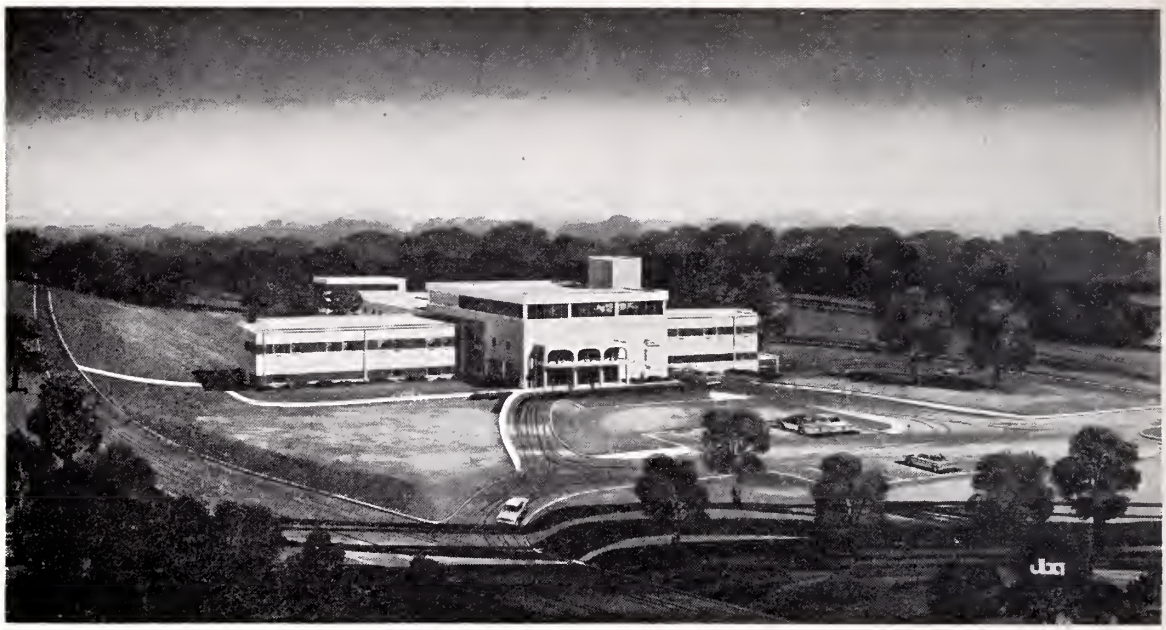

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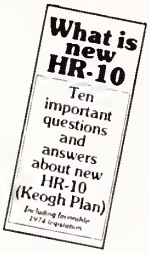

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Rondomycin®
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CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

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The Role of the Detail Man

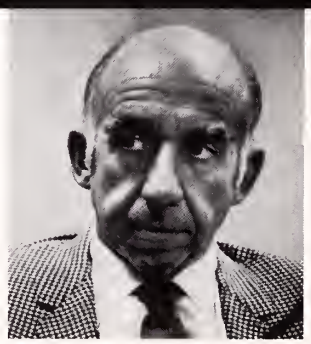
Opinion & Dialogue

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.

Dr. Willard Gobbell
Family Physician
Encino, California



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this countr there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center research people, and academic people have and that's in all likelihd on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in thi

He a Source of Information?

Yes, with certain reservations. ıe average sales representative ıs a great fund of information ıout the drug products he is re- onsible for. He is usually able to ıswer most questions fully and telligently. He can also supply prints of articles that contain a eat deal of information. Here, ɔ, I exercise some caution. I usu- y accept most of the statements ıd opinions that I find in the ıpers and studies which come ɔm the larger teaching facilities. goes without saying that a physi- ɜn should also rely on other urces for his information on ıarmacology.

aining of Sales Representatives

Ideally, a candidate for the ısition as a sales representative a pharmaceutical company ould be a graduate pharmacist ıo has a questioning mind. I don't ink this is possible in every case, ıd so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

ıpacity they are indeed useful; ırticularly in the fact that they sseminate broadly based educa- ɔnal material and serve not just "pushers" of their drugs.

ıe Other Side of the Coin

Obviously, the pharmaceuti- l companies are not producing all is material as a labor of love— ey are in the business of selling oducts for profit. In this regard e ambitious and improperly moti- ted sales representative can ert a negative influence on the acticing physician, both by pre- nting a one-sided picture of his oduct, and by encouraging the actitioner to depend too heavily ı drugs for his total therapy. In ese ways, the salesman has often storted objective reality and ıdermined his potential role as an lucator.

ıe Industry Responsibility

Since the detail man must be ı information resource as well as representative of his particular ıarmaceutical company, he ıould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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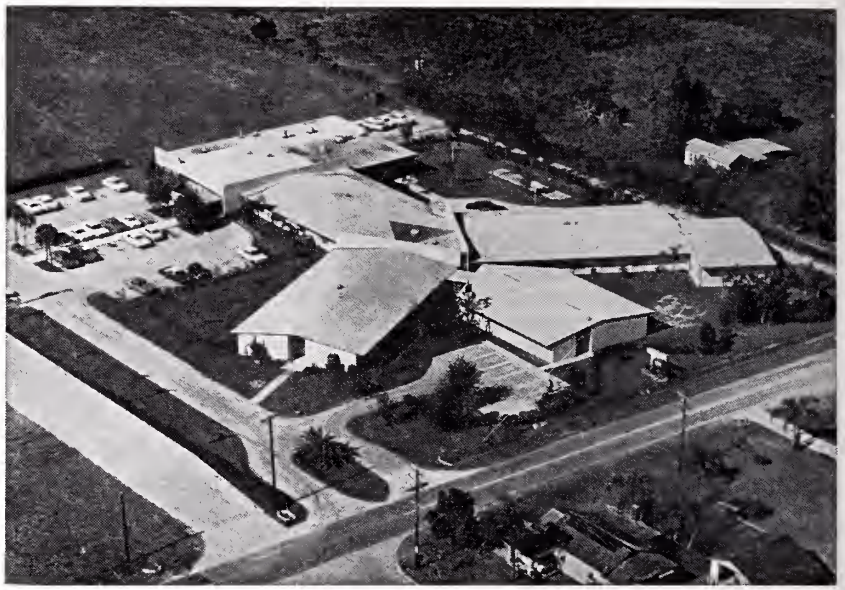

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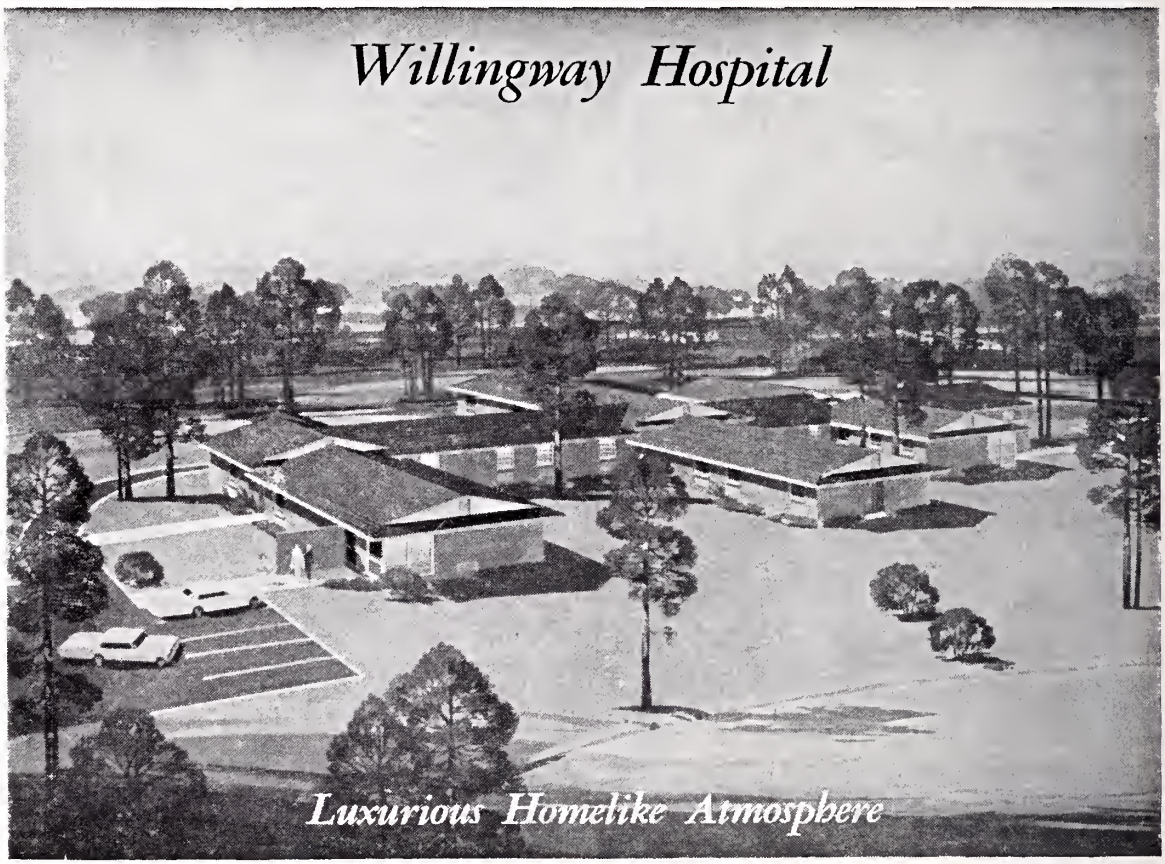

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